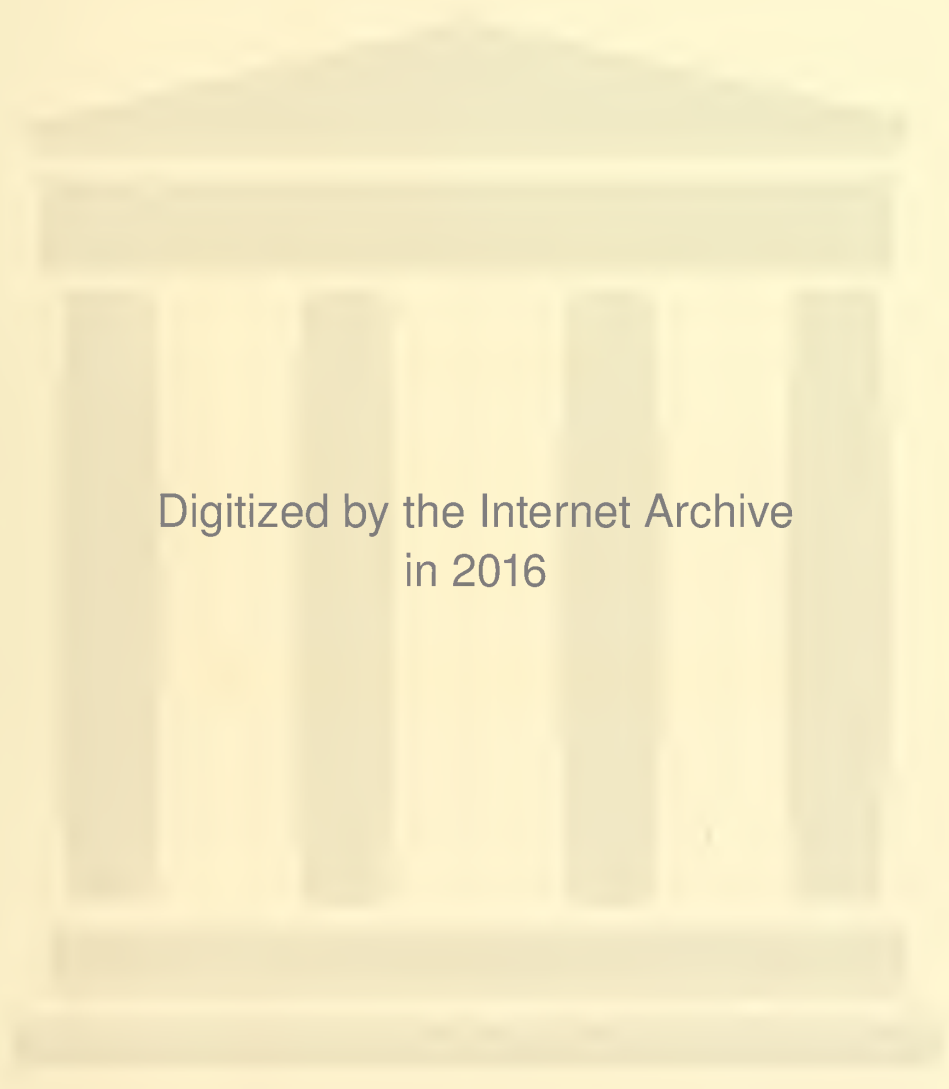


COUNTWAY LIBRARY



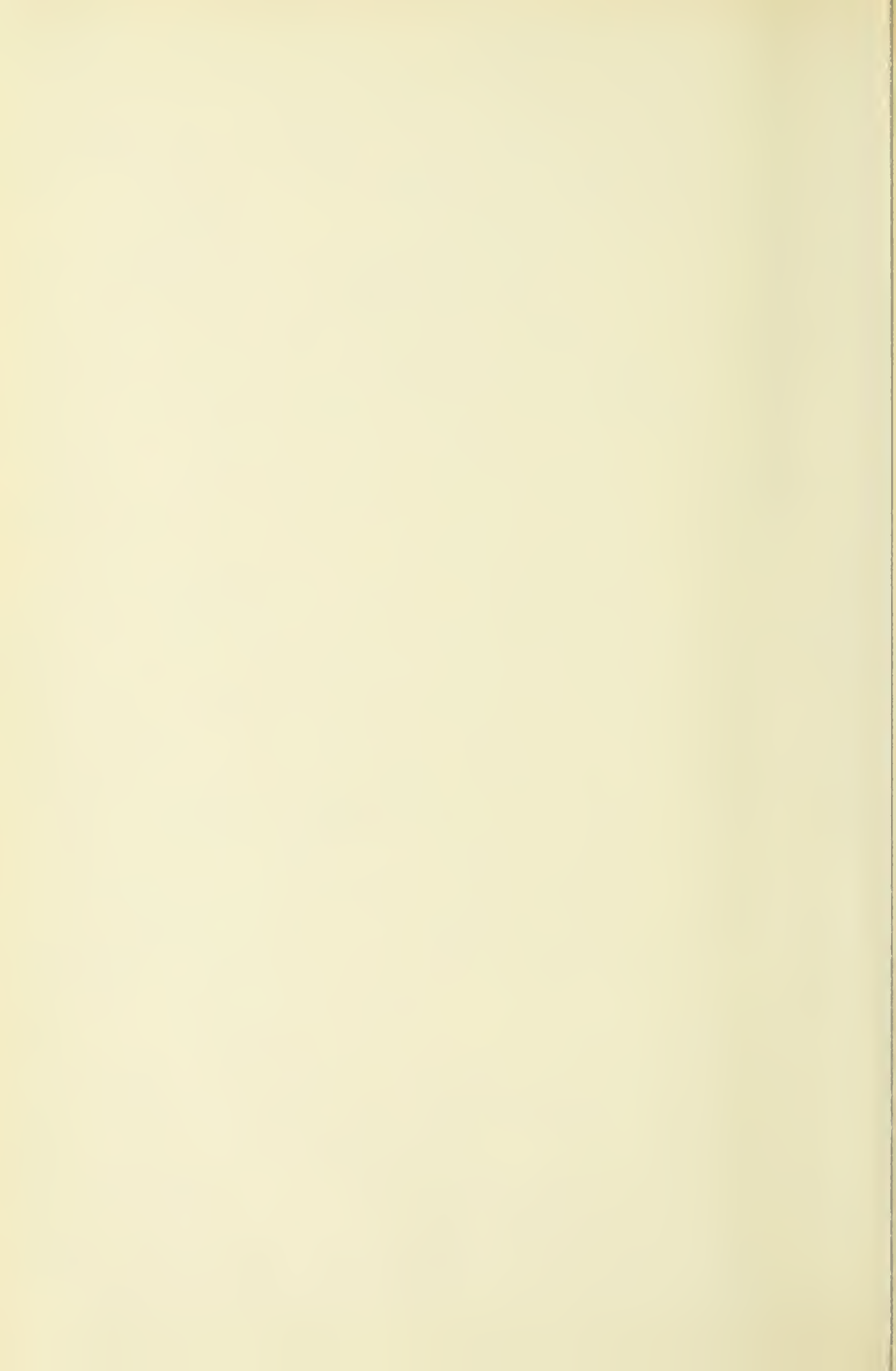
HC 3JF6 \$

BOSTON
MEDICAL LIBRARY
8 THE FENWAY



Digitized by the Internet Archive
in 2016

<https://archive.org/details/journalofsouthca5019sout>





The Journal

of the

South Carolina Medical Association

VOLUME L

January, 1954

NUMBER 1

Rationale of Appendectomy^{*}

EDWIN P. LEHMAN, M. D. AND JULIAN G. SUHRER, M. D.

Charlottesville, Virginia

We have reported two series^{1,2} of over a thousand cases each of acute appendicitis, separated by an interval of about ten years, showing results of treatment in this clinic. The later report, 1943-48, showed marked improvement in mortality coincident with the introduction of antibiotics and other means of protection of the surgical patient. The two reports did not concern themselves with the problems presented by chronic appendicitis or with the removal of normal appendices through diagnostic error.

It has been the belief in this clinic as in others that the protection of the patient with acute appendicitis from the serious disease peritonitis necessarily entails a certain number of diagnostic errors resulting in the removal of normal appendices. This, of course, is a result of the extremely atypical findings present in so many cases of acute appendicitis. We have emphasized the belief that the surgeon's conscience need not trouble him provided a complete history, physical examination, and the so-called routine laboratory studies are carried out before operation, to be followed by additional studies such as x-ray of the chest, ureteral catheterization or electrocardiogram, if the basic studies indicate their importance. It has been our experience that at times cases will be in the wards that have had removal of normal appendices. The present study is designed to find out how large this problem is

in this clinic and how diagnostic error can be decreased. This study is particularly apropos because of the interest which has recently been aroused both in the surgical and lay press in regard to unnecessary operations. Hawley has made the statement that an incidence of greater than 15% of normal appendices excised in operations for acute appendicitis is evidence of unnecessary surgery. He states³ that this figure has been used for years by the American College of Surgeons and is not aware of specific studies on which it is based. The difficulty of accepting it as a standard lies in the fact that the definitions on which the figure is based are not stated. There seem to be at least two factors involved. One is a purely pathological one based on whether the removed appendix does or does not show evidence of acute appendicitis. The second is a clinical standard based on the uncovering of other disease, the preoperative manifestations of which may be extremely difficult to differentiate from those of acute appendicitis. If the pathological standard is used the percentage of normal appendices removed may rise, and correspondingly if the clinical standard is used the incidence of normal appendices removed without cause for the operation will fall.

The present study is based on the operative file of the University of Virginia Hospital Record Room from January, 1950 to December, 1952, so that all cases (1001) that have had appendectomy are included as contrasted with a study only of acute appendicitis. There were no deaths in this series. The material falls naturally into three groups which present differing problems.

^{*} From the Department of Surgery and the University Hospital, University of Virginia.

[†] Read before the South Carolina Chapter, American College of Surgeons, Charleston, S. C., October 19, 1953.

TABLE I
CLASSIFICATION OF APPENDECTOMIES

I. Appendectomy in the course of laparotomy for other disease—the "incidental appendectomy"	498 cases
II. Appendectomy following known or strongly suspected acute appendicitis earlier—the "interval appendix"	15 cases
III. Appendectomy with a preoperative diagnosis of acute appendicitis or possible acute appendicitis	
(a) appendectomy for proven acute appendicitis	348 cases
(b) appendectomy for abdominal pain with the pathological findings of chronic inflammation, scarring or disease elsewhere	103 cases
(c) appendectomy under the diagnosis of possible acute appendicitis with the pathological findings of no disease in the appendix and no disease elsewhere	37 cases
Total	1001 cases

The present study does not include a considerable number of cases admitted for observation and discharged without appendectomy. The three groups will be discussed separately.

Of the 498 incidental appendectomies the largest number were carried out in connection with hysterectomy for leiomyoma of the uterus.

TABLE II

CASES WITH INCIDENTAL APPENDECTOMIES	
Leiomyomata uteri (hysterectomy)	146 cases
Bilateral tubal ligation	103 cases
Gallbladder disease	74 cases
Gastric ulcer	35 cases
Ovarian tumor or cysts	21 cases
Pelvic inflammatory disease	16 cases
Carcinoma of large bowel	14 cases
Carcinoma cervix or endometrium	10 cases
Gastric malignancy	5 cases
Miscellaneous	74 cases
Total	498 cases

The second largest group consists of those carried out on the obstetrical service in connection with bilateral tubal ligation. The attitude of the Department of Obstetrics and Gynecology in this University in regard to sterilization has been discussed in a paper by Williams and Thornton published over ten

years ago.⁴ In that study of 309 cases of bilateral tubal ligation the indications for sterilization are indicated.

TABLE III

INDICATIONS FOR STERILIZATION*	
Excessive multiparity	175 cases
Hypertension and/or nephritis	84 cases
Cardiac and vascular disease	15 cases
Nervous and mental diseases	10 cases
Secondary perineorrhaphy (at delivery)	9 cases
Pyelitis and pyonephrosis	7 cases
Miscellaneous causes (1 case each)	9 cases
Total	309 cases

*From Thornton and Williams, *Am. Jour. Obst. and Gyn.* Vol. 42, p. 54, 1941.

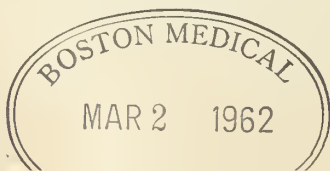
In 178 of this group the appendix was removed and the statement is made "if the appendix is easily available it is removed."

The chief interest in the present group of incidental appendectomies reported here is the occurrence as reported by others of acute inflammation in cases without suspicion that it might be present. There was one such case in the group of 178 appendectomies coincident with bilateral tubal ligation reported by Williams and Thornton. Shelley⁵ reported the occurrence of thirty-three acute appendices in a group of 1890 incidental appendectomies.

TABLE IV

INCIDENTAL APPENDECTOMIES	
No pathological change	228 cases
Pathological change	
Acute inflammation	17 cases
Subacute inflammation	6 cases
Chronic inflammation	47 cases
Scarring or obliteration	149 cases
Lymphoid Hyperplasia	7 cases
Periappendicitis	25 cases
Miscellaneous	19 cases
Total	498 cases

In the present series of 498 incidental appendectomies there were 23 cases showing acute and subacute inflammation in the appendix. That unsuspected acute changes in the appendix may be found on routine appendectomy is, of course, of great interest in connection with the progress of acute appendicitis. It is well known, for instance, that a certain number of cases of acute appendicitis will complain of malaise and inappetence over a period of 24 to 48 hours preceding the onset of pain. Such a complaint might be due to very early acute appendicitis. The discovery of these abnormal



appendices might further suggest that there is more acute appendicitis than we are aware of and that acute appendicitis may exist and resolve without presenting the localized clinical picture of the disease.

It is also interesting that among the 498 cases of incidental appendectomies one unexpected carcinoma and one carcinoid of the appendix were removed. Both of these were detected only on pathological examination of the removed appendix. The finding of these two cases emphasizes further the wisdom of incidental appendectomies in connection with laparotomy for other disease.

Of the total group 15 cases were operated upon for removal of the appendix following the observation of an attack of acute appendicitis here or elsewhere. Many of these were

TABLE V
INTERVAL APPENDECTOMIES

Pathology	Cases	Interval
Subacute inflammation	5	1½-5 mos.
Chronic inflammation	8	½-5 mos.
Lymphoid hyperplasia		
with chronic periappendicitis		
and adhesions	1	3 mos.
No pathological change	1	2 mos.

cases treated during the initial illness for localized peritonitis as a result of appendicitis without operation.¹ It is interesting that of this group of 15 cases only one showed no evidence of past appendicitis. This was a case observed in the supposed acute phase elsewhere and referred to this hospital for appendectomy. The remaining 14 cases all showed inflammatory changes in the appendix, many of them still with subacute changes in the appendix. The accuracy of the diagnosis in this small group of 15 cases suggests at least, although it does not prove, the general accuracy of the diagnosis of appendicitis with a peritoneal reaction.

Group III amounts to 488 cases as has been seen from Table I. It consists of those cases for which laparotomy was done for abdominal pain with a diagnosis of acute appendicitis or possible acute appendicitis. They are subdivided into three subgroups: (Table I)

Subgroup a. Those cases with completely accurate diagnosis of acute appendicitis. (348 cases)

Subgroup b. Those showing scarring or

chronic inflammation of the appendix, or in which disease elsewhere was uncovered. They therefore consist of those cases in which a reasonable cause for laparotomy existed. (103 cases)

Subgroup c. Those cases of completely unnecessary operations, i.e., a normal appendix, and no other disease uncovered. (37 cases)

Obviously the number of diagnostic errors of acute appendicitis is 140 (Subgroup b plus Subgroup c) out of 488 (Group III) or 28.6%. On the other hand if one figures the number of operations for appendectomy carried out without a proven cause for the operation (Subgroup c) the percentage drops to 7.5%. The magnitude of this latter figure is in accordance with the standards used as acceptable by the American College of Surgeons.³

In Subgroup b of Group III the diagnoses most frequently encountered are indicated.

TABLE VI
GROUP III-b APPENDECTOMIES FOR ABDOMINAL PAIN WITH THE PATHOLOGICAL FINDINGS OF CHANGES IN THE APPENDIX OTHER THAN ACUTE INFLAMMATION AND APPENDECTOMIES WITH DISEASE ELSEWHERE.

A. No disease elsewhere:	
Chronic inflammation	27 cases
Scarring of appendix	25 cases
Lymphoid hyperplasia	8 cases
Periappendicitis	3 cases
Infestation with oxyuris vermicularis	3 cases
	<hr/> 66 cases
B. Other disease found:	
Ruptured ovarian follicles or cysts frequently with bleeding	17 cases
Mesenteric adenitis	6 cases
Regional ileitis	5 cases
Pelvic inflammatory disease	3 cases
Gallbladder disease	2 cases
Tubal pregnancy	1 case
Ileocolic intussusception	1 case
Partial obstruction of ileum due to adhesion	1 case
Torsion of omentum with gangrene	1 case
	<hr/> 37 cases
Total	<hr/> 103 cases

C. It is interesting to note that in the 37 appendectomies in which other disease was found (and in which the appendix appeared grossly normal) the appendices showed the following microscopically:

No pathological change	10 cases
Periappendicitis	10 cases
Scarring or obliteration	7 cases
Oxyuris vermicularis infestation	4 cases
Subacute inflammation	2 cases
Early acute inflammation	1 case
Chronic inflammation	1 case
Slight lymphoid hyperplasia	1 case
Serosal vessels packed with lymphocytes	1 case
<hr/>	
Total	37 cases

If one were to use the pathologic criterion offered by study of the appendix alone the figure shown above of 28.6% presents a false picture of our justification for operation. Although the possibility of a mesenteric lymphadenitis or a ruptured follicle has often been considered preoperatively, the frequency of cases of atypical appendicitis has led to exploration under a diagnosis of possible appendicitis. It should be noted that in many of these missed diagnoses the files of the pathology department will contain only a normal appendix.

With the background, as stated earlier, of an adequate history, physical examination and routine laboratory procedure, we do not believe that a safe differential diagnosis can be made between many of these confusing conditions and appendicitis. This point of view has been expounded in an article⁶ of which one of us is co-author. "In approaching the diagnosis of appendicitis, the surgeon must consider all sorts of causes for right-sided abdominal pain, including gastroenteritis, poisonings, the exanthemata, disease of the urinary tract, ruptured ovarian follicle, mesenteric lymphadenitis, ectopic pregnancy, cholecystitis, lumbosacral arthritis, sacroiliac disease, pneumonia, pleurisy, coronary disease, meningitis, psychoneurosis and other conditions. Space will not permit the detailed discussion of the differ-

ential diagnosis of all these diseases. Suffice it to say that (1) a careful complete systems' history, (2) a complete physical examination including a minimal neurologic study, and (3) routine laboratory examination including a study of the stained blood smear will serve to rule out many of the alternative diagnoses. Possibly such study will suggest special investigations that must be made before some of the alternatives can be discarded. A catheterization of the right ureter may be indicated or, especially in children with atypical elevation of pulse, temperature and white cell count, a radiologic examination of the lung fields, or, in older individuals, an electrocardiogram. The surgeon must be particularly alert for an alternative condition that will affect the operative risk. It is much less serious to operate for supposed appendicitis when the disease is a ruptured follicle or a blocked ureter than when it is a coronary occlusion or pneumonia.

"It is unfortunate that the question of operating under a mistaken diagnosis of appendicitis must arise; but there are two reasons why it should arise. The first has already been mentioned, namely, the atypical and confusing picture that actual appendicitis frequently presents. The second is the prohibitive risk of a mistake in the other direction, that is, the missing of a diagnosis of acute appendicitis. Many reports indicate the risk of operating for simple appendicitis as compared to the risk of peritonitis arising from appendicitis. In an earlier series from this clinic before the introduction of chemotherapy and antibiotics, operation for simple appendicitis in 829 cases resulted in a mortality of 0.24 per cent. The total mortality of 240 cases of peritonitis arising from appendicitis, including localized and general peritonitis but excluding the contaminated peritoneum, was 13.7 per cent. The risk in the neglected case, the case in which the diagnosis of appendicitis had been missed either by the patient's failure to consult a doctor or by the doctor himself, was at that time, therefore, nearly sixty times the risk of the diagnosed case. In a later series . . . the contrast is less, but it is still striking. Even with the aid of chemotherapy and antibiotics, the risk of the missed diagnoses is thirteen times that of the diagnosed case. Such ratios put pressure on the

surgeon for appendectomy. No gambler would accept such odds on his own life.

"On account of these two factors, namely (1) the difficulty of diagnosis, and (2) the penalty of a missed diagnosis of appendicitis, it is inevitable that any clinic that sees much of acute appendicitis will perform operations for the disease when it is not present. Their number should not be high. The surgeon can accept a wrong preoperative diagnosis with a good conscience, provided only that he has honestly considered all other possibilities, including especially those that affect operative risk, and has seen to it that his patient has had adequate preoperative study as outlined above. Finally, his conscience cannot be clear unless the patient and the patient's family know the truth. It should be noted that an incidental advantage of a negative exploration for appendicitis, the protection of the patient from future appendicitis by appendectomy, is not listed as a salve to the mistaken surgeon's conscience. It is not mentioned since it can be too easy an escape for the surgeon who operates after inadequate study."

There is no question in our minds that the surgeons at the University of Virginia Hospital are honest thinkers. Furthermore the terms of compensation under the University organization are such that there is no financial pressure for increasing the number of operations done. Although, of course, there unquestionably is such pressure in the case of many surgeons in private practice it does not seem fair to us to condemn them upon the basis of the pathologic study of the appendices removed. There seems to be no black and white measurement of the quality of work done.

It must be made unquestionably clear that the comments and figures presented here do not mean to imply criticism of the point of view of Hawley or of the American College of Surgeons. We believe completely in their motives and we agree that a great many unnecessary (and unjustified) operations are done. We bring up for question only the methods of statistical study and of the standards. The experience in proven acute appendicitis is very great in this institution. During one ten year period we encountered two cases of proven acute appendicitis every three days.

In spite of this wide experience we are still uncertain how to make a definite diagnosis of acute appendicitis in a considerable group of cases. We find ourselves unable to use the typical clinical picture of acute appendicitis as a guide to choice of surgical operation. It is our feeling as said earlier that the only way to protect the patient from peritonitis is to undertake operation on suspicion only. We have been fooled too many times both in the direction of finding only normal appendices and finding unexpected acute appendices. The first group, of course, is unfortunate but the second is a triumph. From our experience in this institution we do not believe that the figure cited by Hawley⁷ of one normal appendix in thirty appendectomies is really "worthy of commendation." In the first place the number of operations is too few and in the second place there is no evidence whatever as to how many cases were allowed to suffer from peritonitis without removing the appendix. Many of the figures cited by Hawley are in the same class. We would not want to scare surgeons from taking out suspected appendices for the sake of collecting only a good figure for the relation between normal and abnormal appendices removed. We do not believe this is the secret of the problem of treating acute appendicitis. It may result in the diminution of unnecessary operations while at the same time increasing the total hazard of appendicitis by failing to remove what may turn out to be a normal appendix. We consider it a questionable sort of standard for this serious and difficult disease.

While the son of one of us was at school he had his appendix removed on the basis of a suspicion of the disease. The attitude toward this procedure was accepted by the father without even a request to see the pathological section of the appendix removed or to hear from the surgeon whether or not he actually had acute appendicitis. The father felt much safer to have the appendix out on a suspicion than not.

It is admitted that this sort of problem is a difficult one dependent entirely on the judgement of the surgeon. We admit that the judgement of some surgeons is bad but we submit that, many times, the judgement is correct al-

though the appendix may prove to have no disease.

In closing we would like to cite briefly the case history of a patient seen and admitted on repeated occasions with right lower abdominal pain before being subjected to operation. The patient was a 17 year old unmarried female at the time of her first admission in 1943. From 1943 to 1951 there were three hospital admissions alternating with two visits to the emergency room. On each occasion the patient complained of right lower abdominal cramping pain of usually four to twelve hours duration and at one time of six days duration. Two episodes were associated with initial nausea and vomiting. Each time there was tenderness to palpation in the right lower abdomen but no spasm or masses or rebound tenderness. A complete history, systems review, physical examination, and basic studies were carried out with nothing of significance being uncovered except for the above mentioned symptoms and findings. Except for the third admission the patient was treated conservatively because of prompt subsidence of signs and symptoms and within a matter of hours had become completely asymptomatic. Since her attacks usually occurred from one to two weeks following a menstrual period it was felt that she might be having ovulatory pain. On the third admission in May 1951, she presented a picture as described above except that there was persistent nausea and aggravation of the right lower abdominal pain by moving or walking around. The patient was carefully watched and because of the persistence of signs and symptoms a diagnosis of possible acute appendicitis was made. The patient was operated upon through a lower right rectus incision. The appendix occupied a retrocecal position and appeared grossly normal except for a few "filmy" adhesions between the terminal ileum, cecum and appendix. The uterus, oviducts, and ovaries appeared normal. The terminal ileum was explored and further exploration and palpation of abdominal viscera revealed no abnormalities. A routine appendectomy was performed. The postoperative course was uneventful. The pathology report was "Appendix, no pathological change." The patient remained asymptomatic until one year following appen-

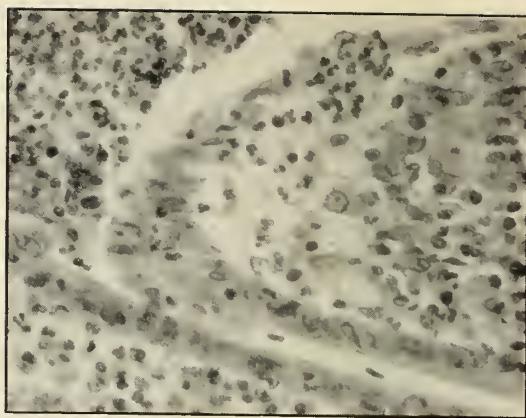


Figure 1. Photomicrograph of cross-section of appendix showing infiltration of mucosa by polymorphonuclear leukocytes. Patient was a 67 year old white female with a history of intermittent right upper abdominal pain of five years duration brought on and aggravated by ingestion of greasy foods. There was no recent acute abdominal pain suggesting acute appendicitis. Cholecystectomy and incidental appendectomy were performed. The pathology department reported chronic cholecystitis with cholelithiasis and early acute appendicitis.

dectomy. At that time she was seen again with the same complaint of right lower quadrant abdominal pain which had subsided completely on a return visit twenty-four hours later. She was last seen in June, 1953, in the dermatology clinic with a contact dermatitis but no further abdominal complaints.

This case has been cited because it illustrates one of the frequent problems in connection with right lower quadrant pain. It is unquestionably clear that it represents unnecessary surgery since the patient has been seen since operation with symptoms similar to those before appendectomy. It is also clear that those who saw her from time to time did not complete the workup, that is, the patient should probably have had ureteral catheterization and psychiatric appraisal. At earlier times when she was seen the pain was so transitory that apparently more complete study did not occur to those who saw her. At the time of appendectomy the pressure for immediate operation was, of course, markedly increased by continuous and increasing pain and other symptoms of gastrointestinal disturbance such as nausea. The department has no pride in this case but presents it solely because it represents a part of the problem.

In general this study shows that judgement on the accuracy of laparotomy for abdominal pain cannot be based only on the pathological findings in a removed appendix. For an accurate estimate of the quality of surgical procedure, as detailed a study must be made in all series as has been made here. Taken with our earlier report² of markedly decreased mortality in proven acute appendicitis the results of this study are not discouraging to the visiting staff of the University of Virginia Hospital.

BIBLIOGRAPHY

1. Lehman, E. P. and W. H. Parker: The Treatment

of Intraperitoneal Abscess Arising from Appendicitis.

Ann. Surg. 108: 833, 1938.

2. Hawk, John C., Jr., W. F. Becker and E. P. Lehman: Acute Appendicitis III: An Analysis of One Thousand and Three Cases.

Ann. Surg. 132: 729, 1950.

3. Hawley, Paul R.: Personal Communication. May, 1953, July, 1953.

4. Thornton, W. H. and T. J. Williams: Sterilization in the Puerperium.

Am. Journal of Obs. and Gyn. 42: 54, 1941.

5. Shelley, Harold J.: Incidence of Asymptomatic Pathologic Conditions of the Appendix. Archives of Surgery 35: 621, 1937.

6. Lehman, E. P., J. C. Hawk, Jr., and W. F. Becker: Appendicitis: With Consideration of the Newer Drugs in Appendiceal Peritonitis.

Surg. Clin. North America, 29: 1985, 1949.

7. Hawley, Paul R.: The Ideals and Ethics of Medicine.

Bull. Am. Coll. of Surgeons. 38: 133, 1953.

In the field of medical education we have delegated to professional educators almost all of the responsibility of arranging the curriculum. Educators are as honest and sincere as the rest of us, but they are not practicing physicians. Perhaps this is why premedical curriculums entirely and medical curriculums almost entirely have too little reference to the needs of medical practice as felt by practicing physicians. If this seems a harsh judgment of the premedical curriculum, others, who may be better qualified than I, have been even harsher. They have not confined their strictures to the premedical course. I am thinking of the report of a committee of educators composed of members of the faculties of preparatory schools and colleges, who concluded that the first two years of college are "a serious waste of time."

Edgar V. Allen, J. A. M. A. June 20, 1953

The emphasis and reliance on mechanical resuscitation gadgets, be they laryngoscopes, air locks, or rocking beds, in my opinion does more harm than good. In my experience positive pressure methods of resuscitation are frequently associated with the production of emphysema and pneumothorax. Emphasis should be concentrated on correcting, before and during delivery, the problems that may cause asphyxia at birth. The Boston Lying-in Hospital is as anxious as any to save more infants' lives, but very conservative methods of resuscitation have been used. In the past five years in 23,967 live births there have been 337 neonatal deaths, a rate of 14 per 1,000 live births. Our policy is to continue our present conservative methods until another procedure has demonstrated better results. Blossom's neonatal mortality before using his air lock was

25 per 1,000 live births, and after a similar period during which he used the air lock his neonatal rate was 19 per 1,000 live births; compared to our own results it suggests that an approach to lowering the death rate might be better based on obstetric factors rather than on mechanical methods of resuscitation.

Stewart H. Clifford, M. D.,

J. A. M. A. 153:473 Oct. 3, 1953

The way to keep open-minded is to be experimental, to be research-minded. This is the great thing, I think, that medical education should strive to achieve. Future doctors should be taught in such a way that they do ask questions—so that they go on asking questions, so that for the rest of their lives they are more interested in new questions than in old answers.

Only in that way, I submit, can they maintain a receptive skepticism—a phrase I made up and rather like—in judging the new; a balance between blind rejection and gullible acceptance. Only in that way, I suggest, can a continuing repetitive experience with the same sorts of diseases and problems be kept from becoming routine and dull. Only in that way can the doctor really continue to think of his patient as a research problem and face him in the research manner. And, of course, for those men who are fortunate enough in time and interest and ability to be able to make a positive contribution to knowledge as well, the research approach is indispensable.

Ralph W. Gerard,

The Epidemiology of Health

Childhood Accidents

BARNES WOODHALL, M. D. AND JAY M. ARENA, M. D.^o

In 1952 there were 96,000 deaths from accidents in this country. The casualty list was reported as 9,700,000. In other words, one out of 17 persons suffered a disabling accident in 1952. In children from one to 14 inclusive, accidents are responsible for approximately 14,000 deaths annually. In this age group accidents take as many lives as pneumonia, dysenteries and diarrhea, measles, diphtheria, meningitis (of all types), whooping cough, scarlet fever and poliomyelitis all combined.

The concept is widely accepted¹ that accident control is largely a function of parents. To exercise this function, parents must be educated so that they can protect the younger child and discipline the older child. The situational patterns of grave childhood accidents show a strong and easily discernible trend toward brutal, monotonous repetition.

Since many victims of childhood accidents are not hospitalized, the pattern of many tragedies can not be found in hospital records. For this reason, all North Carolina newspapers were surveyed for the twelve month period from July 1, 1949, through June 30, 1950, in order to discover the descriptive pattern of all accidents involving children through the age of 15.

Table 1
Deaths and Injuries from Childhood Accidents in N. C.—July, 1949 through June, 1950

Month	No. Children	No. Boys	No. Girls	No. Deaths	No. Injuries
July	60	41	19	32	28
August	74	57	17	53	21
September	32	26	6	20	12
October	65	44	21	31	34
November	46	32	14	17	29
December	48	23	25	27	21
January	35	22	13	13	22
February	47	33	14	17	30
March	40	26	14	19	21
April	37	16	21	18	19
May	33	13	20	23	10
June	35	30	5	24	11
Total	552	363	189	294	258

^oFrom the Departments of Neurosurgery and Pediatrics, Duke University School of Medicine and Duke Hospital, Durham, N. C.

Table 2
Causes of Deaths^o

Motor vehicle	134
Drowning	46
Burns	46
Bicycle	21
Suffocation	13
Guns	12
Electrocution	6
Hanging	4
Train	4
Crushing	4
Poisoning	2
Explosion	1
Fall	1
Total	294

^oFireworks and homicidal attempts were each responsible for two injuries, though no deaths resulted from these causes.

Table 3
Analysis of Injuries Due to Motor Vehicle Accidents
Type of Vehicle

	No. Injuries
Automobile	235
Truck	45
School bus	37
Bus	4
Motorcycle	4
Tractor	2
Total	327

Mode of Accident
Major patterns
No. Injuries

Running in front of vehicle	92
Collision of vehicles	68
Running behind parked car	34
Vehicle out of control	34
Running into side of vehicle	19
Fall from moving car	16
Hit by backing vehicle	7
Recorded as "struck by vehicle"	19
Miscellaneous accidents	19
Not known	19
Total	327

Table 4
Analysis of Injuries Due to Bicycle Accidents
Cause

	No. Injuries
Automobile	33
Truck	3
Fall from bicycle	3
Bus	1
Not known	3
Total	43

Mode of Accident	
Collided with vehicle	7
Riding on right side, made left turn	7
"Struck by vehicle"	5
Fell from bicycle	3
Riding on left side, collision	2
Rode out of driveway in front of car	2
Crossed stop-light, struck by vehicle	2
Crossed in front of car	1
Riding without a tail light	1
Riding on left side of road with no light	1
Unknown	12
Total	43

Table 5

Analysis of Deaths Due to Drowning
Place

	No. Deaths
River	15
Lake	12
Creek	9
Swimming Pool	3
Ditch	2
Home lily pond	1
Sound	1
Not known	3
Total	46

Mode of Accident	
Boat overturned	8
Walked into deep water	7
Fell out of boat	5
Swimming	4
Found in swimming pool	3
Wading	2
Dived from dock	2
Dived from bridge	1
Attempted to cross flooded creek	1
Knocked from trestle by train	1
Fell into ditch	1
Fell into home lily pond	1
Fell from foot bridge	1
Fell from river wiring cable	1
Not known	8
Total	46

Table 6

Analysis of Accidents Involving Firearms
Type of Weapon

	No. Injuries
Rifle	10
Pistol	5
Shot gun	4
Air rifle	2
.45 cal. bullet	1
Unknown	3
Total	25

Mode of Accident	
Shot by companion	8
Found weapon in home	2
Hammered bullet	1
Children fighting over loaded weapon	1
Older person cleaning "unloaded" gun	1
Duel or fight with playmate	1
Loaded gun fell over and discharged	1
Target practice	1
Shooting at rats	1
Shot by father	1
Shot self accidentally	1
Fell and shot self while hunting	1
Suicide	1
Unknown	4
Total	25

Table 7

Analysis of Deaths and Injuries Due to Burns
Mode of Accident

	No. Cases
Left alone in home	21
Kerosene poured in stove, house burned	8
House burned	7
Oil stove exploded; house burned	3
Trailer burned	2
Clothes ignited from fireplace	3
Clothes ignited from trash fire	1
Clothes ignited from open heater	1
Clothes ignited from dump fire	1
Clothes ignited from grass fire	1
Children dropped match in gas tank	3
Can or tank of gasoline ignited	2
Playing with matches	1
Threw insect fluid in fire	1
Lighted kerosene rag thrown on child	1
Fell into scalding water	1
Playing with chemicals	1
Unknown	1
Total	59

Table 8

Analysis of Deaths Due to Suffocation
Mode of Accident

Found in bed	4
Found between bed and wall	3
Caught between sofa and trailer wall	1
Caught between slats of crib	1
Bed clothes over head	1
Choked on toy balloon	1
Peanut in lung	1
Buried by mother	1
Total	13

Accidents Due to Miscellaneous Causes

Total	38
-------	----

The data revealed by this survey of newspaper reports on childhood accidents occurring in North Carolina during 1949 and 1950 apparently indicate a true statistical trend. This

statement is confirmed by the fact that the three most common types of accidental injury reported herein correspond to the three leading causes of fatalities among the 14,000 children who met accidental deaths in the United States in 1947.¹ On the other hand, fatal or near-fatal falls, which represent the fifth most common cause of accidental deaths in children on a nationwide scale, did not appear to command attention in newspapers.

The seasonal incidence of accidental deaths and injuries is portrayed in figure 1. The graphs indicate that the preponderance of accidental injuries occur during out-of-school months. As is to be expected, accidents leading to burns and drownings show a strong seasonal incidence.

Briesen's survey² showed that the highest incidence of head injuries due to auto-pedestrian accidents occurred at the age of 6; of those due to auto-bicycle accidents, between the ages of 11 and 15; and of those due to falls, below the age of 16. According to the data presented in the present report, 32 out of 327 children killed or injured in vehicular accidents were 2 years of age or under. Children in this age group were among the victims of automobile collisions. They and slightly older children opened car doors and fell into the highway. Children in this age group were crushed by cars backing out of garages and down driveways. They sat on fenders and mudguards, or played around standing cars that were put in motion by unobservant drivers.

The children involved in bicycle accidents were in an older age group; only 11 out of 43 were below the age of 10, and only 1 child (aged 4) was less than 5. Most victims of drowning were likewise in this older age group. Young children, including those under 5, however, were left unprotected in boats or fell into shallow water such as ditch water or home lily ponds. Children in the younger age group were the major victims of burns; 44 out of the 59 children who suffered burns were 5 years old or younger.

The situational pattern of various injuries is described in the tables, and the recurring circumstances are readily apparent. Children run in front of vehicles from behind parked cars, and dash into the sides of vehicles. They are

the victims of collisions and are in overturning vehicles. They play around vehicles, and are injured by inattentive drivers. Children ride bicycles on the right side of the road and turn left into vehicles coming from behind. They are allowed to use lethal weapons without training, and to play in the home with loaded guns. They are left alone in homes that burn, or are allowed to play around open fires in the home and outdoors. They may be left unprotected in boats or allowed to play near deep or shallow water.

Bowden³ has commented upon the fact that death by smothering is used as a diagnostic wastebasket; however, small children falling between the bed and the wall succumb to a real form of accidental injury. Finally, the play instincts of small children lead them into devious patterns of accidental injury that can scarcely be foreseen.

Since home accidents are responsible for one-third of the nation's accident fatalities, this then should be stressed in the program of safety education for parents, physicians and all concerned. These accidents were preventable because someone or something was at fault.

The medicines and poisons were not kept out of reach of children or the medicines were not labelled. The electric cords were not in good condition. There were open electric sockets in which children could stick their fingers or tongue or some metal object. The attic and basement were not free of oily rags and litter. The stair treads were not securely fastened down. There were no hand rails on the basement stairs. The stairs and hallways were poorly lighted. The scatter rugs were not fastened down or made slip proof. The radio or electric light pull were too near the bath tub. The hot radiators and pipes were not covered. There was not a gate at the head and foot of the stairs to prevent the small child from falling downstairs or from climbing up. The furniture and lamps were not heavy enough and consequently they could easily be pulled over. The second story windows were not barred to prevent the child from falling out. Handles of the frying pans, coffee pots, etc. on the stove were not turned away. Clothes or toys lying around the floor at night were not

put in place. The baby toys were not free of splinters and sharp edges and they were so small that they could easily be swallowed. The pins, needles, matches and table lighters were not kept out of reach of small children. The firearms were not locked up. The knives and pointed scissors were not kept out of reach of children. Someone or something was at fault.

The facts listed above seem obvious and perhaps trite. Nevertheless, their very simplicity is the reason for repeated emphasis, for despite the efforts thus far, these simple omissions or faults cause the greatest number of hazards and tragedies.

Home accidents are caused by environmental hazards, unsafe actions or a combination of both. Environmental hazards include faulty design, poor housekeeping and im-

proper construction, installation and use of equipment. Unsafe actions can be traced to carelessness, lack of skill, poor health, age, lack of proper instruction and those physical and emotional conditions which affect habits and attitudes.

The problem is one that can not be solved with microscopes and test tubes. Something can be done, however, for accidents do not result from fate, bad luck or circumstances beyond human control. They can be prevented!

REFERENCES

1. Dietrich, H. F.: Accidents, Childhood's Greatest Physical Threat, are Preventable, J.A.M.A. 144:1174 (Dec. 2) 1950.
2. Briesen, H.: A Head Injury Survey, U. S. Navy M. Bull. 38:483-493 (Oct.) 1940.
3. Bowden, K.: Sudden Death or Alleged Accidental Suffocation in Babies, M. J. Austral. 1:65-72 (Jan. 21) 1950.

Medicine is moving from attempts to cure disturbances relatively late to attempts to abort them relatively early, or to prevent them altogether. Or, if I may paraphrase that, I think medicine is moving from surgery towards internal medicine.

Let me now hasten to reassure surgeons that this does not in my mind mean that surgery is done. On the contrary, surgery is expanding tremendously; but it is expanding at the periphery by being able to attack wider and wider fields, or more and more intricate and seemingly inaccessible regions of the body. But note, parenthetically, that it is able to do this not by any advance in anatomical or pathological knowledge, but by advances in functional knowledge, physiological and chemical knowledge. Anesthesia, asepsis, methods of artificial respiration, anticoagulants, antibiotics, non-reactive prostheses and other special gadgetry—these are the things that make it possible for surgeons now not merely to go into the abdomen—which was quite a novelty a century ago—and into the chest—a novelty of a few decades ago—and into the head, but also into the heart and into the lungs and so on.

*Ralph W. Gerard,
The Epidemiology of Health*

Who could know better the essentials of medical education than those who are the recipients of it and who apply what they learned in daily practice? I have talked to many physicians in practice and to many fellows of the Mayo Foundation. They believe, with minor exceptions, that there is much in

medical education that is useless, impractical, and anachronistic. The defense usually made by professional educators is that some subjects have for their purpose mental discipline. To this I object. Mental discipline should have been imposed in preparatory school and in the premedical years. What further of this remains to be done in the professional school can be effected better by study of subjects that are useful, practical, and timely.

Edgar V. Allen, J. A. M. A. June 20, 1953

A furore was created in medical circles many years ago when Raymond Pearl published his study of mortality rates in various communities. Some of you will recall that he had impeccable figures which showed the death rate was high in those communities that had poorly trained doctors, as judged by their background, was lower in communities that had better trained doctors, and was still lower in communities that had extremely well trained doctors. The thing that caused the trouble was that it was lowest of all in communities that had no doctors.

I do not know what was wrong with the statistics, but they make me think of the young doctor, just starting practice, who rushed into the health office, saying, "Oh, that death certificate I signed yesterday, I want it back. I made a mistake and signed my name under the line where it says, 'Cause of death,'"

*Ralph W. Gerard,
The Epidemiology of Health*

Cleft Lip

The Surgical Development and Present Status

ROBERT F. HAGERTY, M. D.*

Cleft lip is the result of the incomplete closure of the maxillary and nasofrontal processes during the first trimester of pregnancy. The only etiological factor for this defect in humans for which we have any good evidence is heredity. Probably the most complete analysis of this factor was made by Fogh-Anderson¹ whose work was carried out in the relatively stable population of Denmark. In that country about one child in 665 has cleft lip or cleft palate. Of these, about 25% have cleft lip, 50% cleft lip and cleft palate, and 25% cleft palate, the majority of the first two categories being males and of the third category, females. Ten per cent or more of these patients have severe associated malformations, but the majority of this group are stillborn or die shortly after birth. About 25% of the children with cleft lip or cleft palate die within the first year of life. After the first year the mortality is not much higher than that found in the population at large. The following important facts of genetic prognosis are brought to light: (1) In normal parents with one defective child, the chance of the next child being defective is 4.4%. (2) If one parent is defective, (and there are no children or normal children) the chance of the next child being defective is 2.0%. (3) If one parent is defective and there is one defective child, the chance of the next child being defective is 14%. We have no proof or even good evidence that the cleft defect in humans is due to diet, syphilis, parental age, maternal impressions, intra-uterine trauma, German measles or other known disease.

The pathological anatomy of cleft lip usually involves the nose, whether the cleft be incomplete or complete, that is, through the floor of the nostril. In unilateral cleft lip the nostril on the cleft side is more transverse than that of its fellow and the nose is correspondingly flattened. The base of the columella and septum is oblique. The base of the ala is inferior on

the cleft side and there seems to be an excess of tissue in the upper part of the lip with a deficit below. For some strange reason the cleft appears more frequently on the left side than on the right. In the majority of cases in which the cleft extends as far as half way through the lip, there is little or no muscle tissue between the upper angle of the cleft and floor of the nostril. According to Veau² the types of cleft appear in approximately the percentages as shown in illustration #1. From this one can see that about three-fourths of all cleft lips are unilateral and about half are unilateral complete.

The progress of cleft lip surgery is interesting to trace, especially if we keep in mind the ideals which guide us in repairing this defect today. First, bearing in mind that a cleft is repaired for both aesthetic and functional reasons, the line of incision should be such that (a) the musculature is approximated, (b) a flap extends across the free margin of the lip below the suture line to prevent notching, and (c) the line itself is broken to divert the eye of the observer rather than to proclaim the defect by a straight and obvious scar. Second, the lower third of the upper lip should have a generous pout, a very characteristic feature of a baby's mouth and vitally necessary to the development of a normal lip. Third, the defect of the nostril should be corrected, and fourth, the cupid's bow should be restored.

With these criteria in mind we can briefly review the progress of several centuries. The work of Celsus in the first century, who freshened the borders of the cleft, mobilized the lip and cheek by undercutting and approximated the margins by simple suture, was soon forgotten. In the eighteenth century escharotics, clamps and bandages were still substituted for the rational treatment of the ancient physicians. In the nineteenth century denudation and approximation of the cleft borders in a straight line were carried out at first with a resultant flat lip which became

*Department of Surgery (Plastic Surgery), Medical College of South Carolina.



ILLUSTRATION 1

notched at its free border when the scar contracted.

The first recorded improvement upon these straight incisions was that of the British surgeon Husson in 1836. He used curved incisions with their convexities toward the cleft. When these curved lines are approximated, an overly long lip is obtained in an attempt at over-correction for the eventual scar contracture. A slight pout is also produced at the free margin of the lip because of the excess of tissue there after the widest points of the arcs are approximated superiorly.

Mirault,³ in 1844, made one of the greatest contributions to lip surgery by swinging a triangular flap across the suture line at the free border of the lip. This not only reduces the notching from scar contracture but also gives some fullness to the lower part of the lip and partially camouflages the suture line by

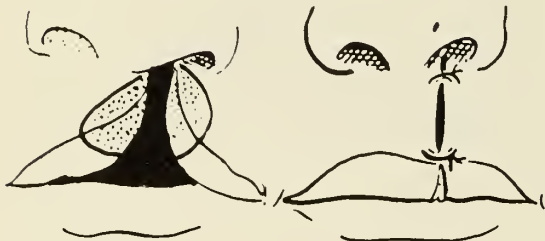
bending it. The principle of carrying a flap across a suture line on any free margin is an accepted one in plastic surgery and is widely used to prevent notching of such free margins as the helix of the ear and the margin of the eyelid.

Near the close of the century in 1892 Hagedorn⁴ introduced the rectangular flap technique. For the first time the suture line was completely broken with elimination of notching from scar contracture and restoration of the cupid's bow. In addition an increased fullness or pout was secured at the free border of the lip.

Perhaps the greatest contribution to cleft lip work in the United States was published by V. P. Blair and J. B. Brown in 1930.⁵ Here the Mirault operation, with the triangular flap, was outlined with the exactness of architectural engineers, and the care of the nose was de-



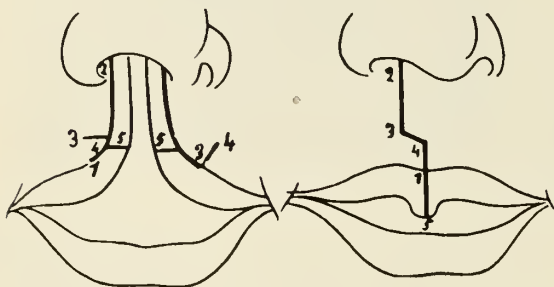
PRIMITIVE: This type of lip repair, which is carried out in a straight line through a soft tissue with a free border, such as the lip, results in a notching of the lip as the scar contracts. The scar line is obvious, the lip is flat or even depressed and the cupid's bow is absent.



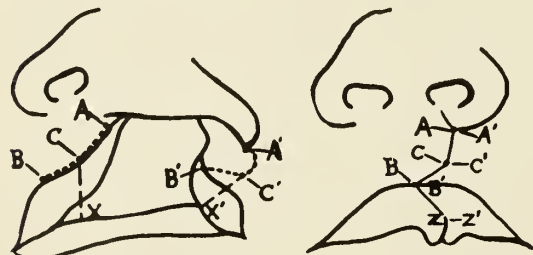
HUSSON, 1836: With the approximation of such curved suture lines, the greatest stress is taken up by the widest points in the curves, giving a relative fullness or pout to the inferior free border. In addition the approximation of curved lines produces a longer line of closure than the apposition of straight one, thus over-correcting the length of the lip in anticipation of its eventual contracture along the suture line.



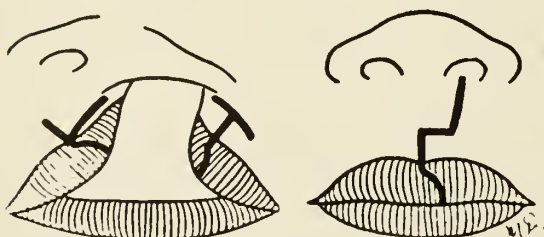
MIRAULT, 1884: By swinging a triangular flap across the suture line at the free border of the lip, not only is the notching from the scar contracture greatly reduced, but also some fullness or pout is added to the lower part of the lip. In addition the suture line is partially camouflaged by bending.



HAGEDORN, 1892: The use of a rectangular flap across the suture line at the free border of the lip eliminates notching from scar contracture, gives the best camouflage of the suture line, markedly increases the fullness or pout at the free border, and restores the cupid's bow.



BLAIR, BROWN, 1930: The Mirault operation is carried to the ultimate of its possibilities by this perfection of technique. Their handling of the nasal defect is still the accepted approach to this problem today.



LE MESURIER, 1949: This is the ultimate expression of all the advances made to date in the correction of the lip defect. The curved incisions of Husson and the rectangular flap of Hagedorn are combined in an ingenious fashion. The suture line is broken, not just bent, thus effectively diverting the observer's eye and eliminating the possibility of notching secondary to scar contracture. A generous pout or fullness of the lower lip is provided by both the rectangular flap (carrying about twice as much tissue as a triangular flap) and by the curved incisions. The cupid's bow is restored more effectively than in any other operation.

ILLUSTRATION 2



CASE 1



CASE 2



ILLUSTRATION 3

scribed and illustrated so well that it remains as the classical approach to the nasal defect today.

This operation became the accepted technique of cleft lip repair until Le Mesurier⁶ of Toronto presented some of his cases to a group of American plastic surgeons and published his technique in 1949. In the care of the lip this technique has no equal. Essentially, it is accomplished by rotating a rectangular flap across the suture line from the lateral side of the cleft to the medial. It is similar in this respect to the procedure of Hagedorn, but incorporates a technical perfection which Hagedorn never dreamed of. Blair and Brown made this statement, "The logic of the Mirault plan is that a flap is taken from the upper part of the lip where there is excess tissue and implanted in the lower border where tissue is most needed." The Le Mesurier rectangular flap, about twice the size of the Mirault triangular flap, is just that much more effective. In addition the scar line is broken, not bent, Husson's curved incisions are incorporated to give a maximum pout or fullness to the free margin and complete reconstruction of the cupid's bow is effected.

Thus, in reviewing the salient points in cleft lip repair, we find the rectangular flap technique of Le Mesurier to give a preferable scar line, first, because it is a broken one, not just bent. The observer's eye is more distracted and there is no likelihood of contracture or notching of the vermilion border. Second, the maximal pout of the lower third of the upper lip is produced by this technique, both because about twice as much tissue is transferred by the use of a rectangular flap as compared with a triangular one, and also Husson's curved incisions are used. Third, the cupid's bow can be restored more effectively than by any other procedure. Diagrams of these techniques with descriptions of their salient features are seen in illustration #2.

In illustration #3 are pictured the first two cases which I have had the opportunity to repair since joining the Surgical Staff of the Medical College as plastic surgeon. They are selected because they represent a random sample, show average results and have the longest post-operative period for follow-up.

Case 1. E. C. from Williamsburg County was born on March 14, 1953 with a complete unilateral cleft lip (left) and a complete cleft palate. No family history of any cleft defects or other congenital abnormality was found. She was admitted to Roper Hospital on June 7, 1953 and given a transfusion of 65 cc. of whole blood to correct her anemia. On June 9 the lip defect was closed by the Le Mesurier technique. Post-operatively she was again transfused with 90 cc. of blood. Her post-operative course was uneventful and she was discharged from the hospital on June 18. On Sept. 16 the accompanying photographs were taken.

Case 2. S. W. from Charleston County was born Aug. 2, 1953 with a complete unilateral cleft lip (right) and a complete cleft palate. No familial history of any cleft defect or other congenital abnormality was elicited. She was admitted on June 3, 1953 and given 150 cc. of whole blood on two successive days because of anemia. On June 5 the lip defect was repaired by the method of Le Mesurier. Post-operatively this child had an excessive nasal discharge with poor healing of the suture line. She was discharged on June 18 and returned for photographs on Sept. 16.

The lateral photographs, both pre-operatively and post-operatively, show an abnormal fullness of the upper third of the lip caused by the forward displacement of the alveolar arch, which has sprung open as a result of the cleft. The constant pull of the lip musculature will mold this back into position and close the alveolar cleft to a great extent. The heavy scarring in case 2 is associated with a chronic nasal discharge which the child still has. Although but one type of cleft is shown, the same basic technique is used in a modified form in all types of cleft lip deformities, both unilateral and bilateral.

The preferable time to close these lip defects is about three months of age. This allows the infant to attain a fair size and precedes the ossification of the midfacial bones, which are molded into position by the lip musculature after the lip closure. To operate earlier is to satisfy the parents rather than the child. Although the growth in three months is not great, still the margin of surgical error is reduced. A

small discrepancy in an infant will be a large one in an adult. To think that one can easily correct his mistakes later by revision is quite erroneous. The first operation is by far the most important one. Scars and deformities can be produced by the surgeon untrained in this field which will leave the child with the stigma of a cleft lip all his life. Typical of these unsuccessful operations are the wide nostril floor, the non-pouting flat lip with a notched vermilion, the straight or only slightly curved scar line and the complete absence of the cupid's bow.

Pre-operatively and two weeks post-operatively, these infants are fed with an Asepto syringe, having a short rubber tube attached to its tip. Each child is examined by our pediatric consultant before operation. In case there is some contraindication to general anesthesia, such as cardiac disease, the operation is carried out under local anesthesia. In these cases the results are usually less satisfying. The children are then followed at regular intervals in our Plastic-Surgery Clinic.

SUMMARY AND CONCLUSIONS

To the best of our knowledge cleft lip (formerly "hare lip" in our more rural past) is an hereditary affliction. The progress of surgery in this field has been neither rapid nor

constant. The apposition of the cleft margins was first carried out in straight lines, then in curved ones. A decisive advance was made in carrying a flap (first triangular then rectangular) across the line of incision at the free border of the lip. The triangular flap method was highly developed along with the care of the nasal defect. Finally an ingenious combination of the curved incisions and the rectangular flap now appears to give the best results.

The preferable time of operation is about three months. Until the defect is repaired, the use of an Asepto syringe with a short rubber tube attached to its tip allows normal feeding and growth in these infants.

BIBLIOGRAPHY

1. Fogh-Anderson, Paul, Inheritance of Cleft Lip and Cleft Palate. NYT Nordisk Forlag, Arnold Busch, Copenhagen, (1942).
2. Veau, Victor, Bec-de-Lievre. Masson et Cie, Paris, France, (1938).
3. Mirault, Operation for Harelip. J. de Chir., II:257, (1844).
4. Hagedorn, Die Operation der Hansenschartz mit Zickzacknaht. Centralbl. f. Chir., Leipz., xix:281-285, (1892).
5. Blair, Wilray P. and Brown, J. B., Mirault Operation for Single Harelip. Surg., Gyn. & Obst. 51:81-98, (1930).
6. Le Mesurier, A. B., A Method of Cutting and Suturing the Lip in the Treatment of Complete Unilateral Clefts. Journal of Plastic and Reconstructive Surgery, 4:1-12, (1949).

I am told, also, that the scholar, trained to read accurately, to think consecutively and with infinite care, to record only that which before has not been recorded or sufficiently interpreted, will find little in a medical atmosphere that he can recognize as scholarship. He will applaud the amazing technical proficiency with which the physician's vocational training endows him but, if he reads in the medical library, he will deplore the plethora of redundant material, the incoherence, the faulty sentence structure, the inexact quotation, and the wretched arithmetic. The fault lies, I believe, not greatly with the physician himself. He cannot know that with which he has never been made acquainted. The fault can be identified, I believe, as one of the blind spots in the eyes of those who direct education, including pre-medical education: the failure thoroughly to ground young students in grammar, rhetoric, and composition, the essentials to competence in written or spoken exposition. There grows from this deficiency an unhappy situation. A major part of the contact a physician can effect with his patients, his public, and his

professional colleagues is by means of what he writes and says; yet he was not taught, when he was preparing for the study of medicine, to write, speak, or refrain from writing or speaking.

Edgar V. Allen, J. A. M. A. June 20, 1953

I believe in the profession of medicine. I am thankful for that improbable chance that, in an earlier day, took me out of a school of engineering into premedical study. I would rather be of the physician's guild than a follower of any other occupation of which I know. I believe that no profession offers better opportunity for growth in moral and ethical stature, for contribution to the welfare of society, and for relief of individual human suffering. I believe that no profession permits the practitioner to approach so closely the goals of kindness, loyalty, devotion, and consecration as does medicine. If I find, as you must, flaws in the wide surface of the portrait that represents us, I believe them to constitute only a challenge to us to strive more diligently toward perfection.

Edgar V. Allen, J. A. M. A. June 20, 1953

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain Mullins
J. D. Guess Greenville
C. J. Milling Columbia
H. R. Pratt-Thomas Charleston

Vince Moseley Charleston
Ben Miller Columbia
W. H. Prioleau Charleston

G. D. Johnson Spartanburg
R. M. Pollitzer Greenville
Hugh Smith Greenville
Walter Mead Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Charleston, S. C.

Subscription Price

\$3.00 a Year

JANUARY, 1954

PROMISE FOR POLIO

High hopes for the efficacy of gamma globulin have met much discouragement after last year's experience. The figures are not yet analyzed completely, but impressions are pessimistic.

The next move in the fight against poliomyelitis is the use of a vaccine which promises much from experimental evidence but needs the verification of a wide experience in actual use in epidemic areas. Dr. Salk's vaccine is a killed vaccine and has been proven harmless and effectively antigenic. The practical protection remains to be proven by widespread use under field conditions.

Not all virologists approve of the Salk vaccine, especially those who believe that an attenuated vaccine, whenever it might be developed from studies in process, will offer better and longer protection. But since such a vaccine is not in sight, The National Foundation for Infantile Paralysis is preparing to provide funds and ways to give a thorough trial to the Salk material. The present plan is to vaccinate in a series of three doses about one third of all the second-grade children of the country before the usual time of the beginning of the polio epidemics, and to obtain from country-wide statistics information which should establish (or discredit) the value of the killed vaccine. More extensive use is limited by the available supply of vaccine and limited, though large, funds.

South Carolina will participate in this effort, which will be directed jointly by the Foundation and our State Board of Health. Activities will begin very soon, and it should be the de-

sire of every physician in the state to give all possible assistance to an effort which might lead eventually to the control of an increasingly prevalent and terrifying disease.

BABEL IN BRIEF

Those of us who have occasion to read charts are frequently puzzled by the weird sets of abbreviations which spring from the fertile time-saving minds of those who work in hospitals. Further confusion arises from the situation in which a set of letters means one thing to one service and entirely a different thing to another. Such peculiarities are not confined to house staffs. They are beginning to appear in reputable journals and textbooks, and the reader must have a keen memory and imagination to keep pace with his A B C.

Abbreviation seems to be established as a hospital practice, and to try to stem the alphabetical tide perhaps would be fruitless. However, there should be an agreement among all parties as to the meanings intended, and there should be a prohibition of freehand individual inspiration in the matter of new alphabetical terms. There seems to be a need for some sort of booklet which might be called an abbreviationary, so that the trend to medical literary obscurity may be somewhat less obscure.

ANTI — ANTIBIOTICS

The therapeutic nihilist is now a rare character. Perhaps he has been replaced by the therapeutic annihilator. There must be some moderate element which remembers or believes that there was a time when patients managed to get well without all the expensive

therapy of today. It is unfortunate that the wonders of our new drugs are often obscured by ill-considered use.

A NEW EDITOR AND A NEW BOARD

With this issue Dr. Julian Price slips voluntarily and gracefully from the editorial chair which he has adorned for many years and makes room for a new appointee. Dr. Price leaves a job well done and goes on to new experiences and contributions on the Board of Trustees of the American Medical Association. That he will be as successful and effective there as he has been with *The Journal* here there is no doubt.

A new editor and a new editorial board will strive to publish a *Journal* which is acceptable to the members of the South Carolina Medical Association. Without suggestion and criticism from these members there must be a considerable amount of guessing and floundering by the editorial staff. Therefore comments and contributions of all sorts are desired and invited.

A few changes in the cover and the type have been made in this issue. The possibilities for new arrangements and new material are endless, and new ideas from all members are sought sincerely.

An editor has said—"To say that the journal of a state medical association is as good as its editors is also to say that it is only as good as the material the members provide for their utilization. No matter how well it is staffed and managed, no matter how attractive its format, its success depends primarily on the subject matter provided by the members."*

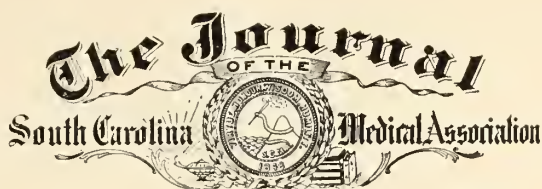
*Shaler Richardson, M. D., Jacksonville, Fla. "The Successful State Medical Journal," JOURNAL OF THE MEDICAL ASSOCIATION OF GEORGIA, 1953.

COASTAL MEDICAL SOCIETY

The Coastal Medical Society, composed of 120 doctors from Charleston, Berkeley, Beaufort, Colleton, Dorchester, Allendale, Jasper, and Hampton counties, held its November meeting at the Lewisfield Plantation, Moncks Corner, on Thursday evening, November 19th at 6:00 P. M.

The Moncks Corner group were hosts for this meeting. Speaker at the scientific session was Dr. John van de Erve, Jr., of Charleston, who presented a talk illustrated with slides on "Recent Advances in Dermatology."

During the afternoon a fishing party was arranged for those members who could come early. Social hour began at 6:00 P. M., followed by the scientific session at 7:00. After a buffet barbecue dinner the meeting was adjourned by Dr. A. R. Johnston, President, of St. George. H. E. Carter, Sec. Treas.



Forty Years Ago

Seneca, S. C.

January 1914

Dr. Robert Wilson reported a budget of \$34,320. for the next session of the Medical College. . . Dr. William Weston called a meeting of the representative members from the county societies to discuss greater efforts in behalf of Public Health. . . . *The Journal* refused all advertising not accepted by the Council on Pharmacy and Chemistry of the A. M. A. . . A paper by Dr. T. G. Croft of Aiken was on "Autotoxemia and Acidosis". . . A paper on "What the Spartanburg County Medical Society is Doing for the Present Pellagra Situation" was presented. . . Abbeville County reported a series of meetings with 'possum, turkey, and goose suppers. . . Greenville County had established a medical library and had passed resolutions on a "black-list."

CORRESPONDENCE

November 18, 1953

Dr. J. Howard Stokes
125 West Cheves Street
Florence, S. C.

Dear Howard:

Once upon a time there was in the *Journal* a very lively and widely read column by that eminent philosopher, Aero Sakos. Would there be a possibility that this most desirable feature might be revived in a *Journal* which comes under the direction of a new Editor within a very short time?

With best regards,

Sincerely yours,
J. I. Waring, M. D.

November 23, 1953

Dr. J. I. Waring
82 Rutledge Avenue
Charleston, S. C.

Dear Joe,

Old Aero Sakos stands ready willing and he hopes—able to assist our new editor of the *Journal* of the South Carolina Medical Association. Perhaps with a new Editor and a new column, we will once again

have a worthwhile Journal. Something certainly lacking during the past several years.

Kindest regards,
J. Howard Stokes, M. D.

November 28, 1953

Dr. Howard Stokes
161 W. Cheves Street
Florence, S. C.

Dear Howard:

You fill my heart with joy, and I am prepared to cackle over Aero Sakos at as early a date as may be convenient for you.

Many thanks.

Kindest regards,
J. I. Waring, M. D.

25 November 53

Dr. J. I. Waring
82 Rutledge Avenue
Charleston, S. C.

Dear Dr. Waring:

It has come to my attention that J. Howard Stokes is attempting to enter some of his diabolical writings in the Journal of the South Carolina Medical Association. When I was still young and innocent in the editorial field, I fell into his snare and I would like to warn you against him.

Under the assumed name of Aero Sakos I accepted some of his material for publication in the Journal. I did not pay much attention to the protests from our readers but when the U. S. Postal authorities threatened suit for the vile content of his writings. I quickly desisted. When there was a great up-surge in the progress of our Journal, after we got rid of this character, I was proud of the stand which I had taken.

Please do not fall for the blandishments of this American Vishinsky.

Yours sincerely,
Julian P. Price, M. D.

December 1, 1953

Dr. Julian McCarthy Price,
117 W. Cheves Street,
Florence, S. C.

Dear Dr. Price:

I am indeed grateful to you for your warning about this fellow Aero Sakos, otherwise known as Stokeschinsky. As a new editor, I would be very sorry to make any miStokes so early in my career.

Do you think it might be all right to encourage him so long as we keep his column on the left side of the page and identify it by printing it in some of our Lilly-red ink?

Please keep me advised of his activities.

Sincerely yours,
J. I. Waring, M. D.

NEWS ITEMS

GROUP MAKES PLANS FOR POLIO VACCINATION

COLUMBIA, S. C.—DEC. 14, 1953

Health, education and medical authorities of South Carolina met here Monday with representatives of the National Foundation for Infantile Paralysis to lay preliminary plans for the polio prevention test program in this state next year.

Vaccinations in South Carolina—part of the largest test program of its kind in medical history—will help determine the effectiveness of a new trial vaccine in preventing paralytic polio.

Meeting with Dr. Ben F. Wyman, State Health Officer, under whose direction the polio trials will be carried out in this state, were:

Dr. G. E. McDaniel, Dr. C. L. Guyton, Dr. G. S. T. Peebles and Dr. Hilla Sheriff, all of the State Health Department; Dr. Joseph I. Waring, Charleston, chairman of the Polio Committee, and Drs. W. Wyman King, Batesburg, and W. M. Hart, Florence, members of Dr. Waring's committee.

The National Foundation for Infantile Paralysis was represented by Dr. John Marchand, New York, special regional medical consultant; Horace B. Ward and J. Paul Taylor, state representatives, and Mrs. Laurence L. Smith of Columbia, state women's advisor.

Similar planning meetings are scheduled in all states before the trial vaccinations of 500,000 to 1,000,000 second grade school children in more than 200 communities of the nation. The program will first get under way the week of Feb. 8 in the South. It will be completed everywhere by the first of June. The counties or local areas in which the tests will be undertaken and the exact dates for these vaccinations are not yet determined.

Local doctors will be asked to contribute their services to administer the trial vaccine. They will have the volunteer assistance of local nurses, health officers, teachers and members of County Chapters of the National Foundation. The County Health Officer and National Foundation Chapter leaders will co-operate to carry out the program, keep records and follow up with the necessary checks throughout the ensuing "polio season."

The National Foundation will provide the trial vaccine without cost to participants. Arrangements were discussed at the meeting for handling these supplies and equipment which the National Foundation will send to the State Health Officer, who will facilitate the reshipment to selected counties.

In the designated areas each second grade student whose parents request the inoculations will receive three "shots" in the arm in the trial study. The first two will be one week apart. The third, or "booster shot," will be given at least four weeks after the second. The results will be checked during the remainder of 1954 against the health records of first and third grade children in the same schools, who will not have been vaccinated.

Dr. Jonas E. Salk, Pittsburgh, a March of Dimes grantee, developed the new trial vaccine. Every batch will be subjected to three rigid, scientific tests for safety before it is used. These tests will be made by the Laboratory of Biologics Control of the National Institutes of Health (a unit of the U. S. Public Health Service), by Dr. Salk's laboratories at the University of Pittsburgh, and by each commercial laboratory producing the vaccine.

Dr. Dechard Guess who was ill in Charleston has returned to his home in Greenville.

Dr. Lucius Cline of Greenville is now at the Naval Base at Charleston.

The Orangeburg Regional Hospital has begun construction on its new building.

Dr. Robert Lee Sanders, president-elect of the Southern Medical Association is a South Carolinian who left his native heath to settle in Memphis. Born near Anderson, he practiced in Anderson for eight years before going to the Mayo Clinic and elsewhere.

Dr. William Weston, Jr. has been elected Chairman for District IV of the American Academy of Pediatrics.

Dr. Wm. Byerly of Hartsville is the 1954 president of the Pee Dee Medical Association.

Ground has been broken for the construction of a hospital at Myrtle Beach.

Recently a bronze marker was placed on the grounds of the Colleton County Hospital to designate a group of live oaks planted by patients and friends of Dr. Riddick Ackerman as a tribute to his many services.

The Pee Dee Medical Association held its 105th annual meeting in Florence on October 15, 1953. A symposium on Rheumatic Fever was presented by Drs. Peters and Craig of the University of North Carolina.

Dr. F. E. Kredel of Charleston has been reelected to the Board of Governors of the American College of Surgeons.

Dr. John Brown of Charleston is now president of the South Carolina Society of Anaesthesiologists.

The Governor of South Carolina has appointed Drs. L. Emmett Madden, Dr. Harold Jervey, Dr. A. R. Johnston, and Dr. Wm. P. Turner to the State Board of Medical Examiners.

The Greenville Medical Society has arranged for a series of six medical forums for the public, beginning in January 1954.

Dr. Bryan Michaux of Dillon is now head of the Association of Seaboard Air Line Railway Surgeons.

Dr. H. L. Lafitte, Allendale, has been elected a member of the Board of the South Carolina Tuberculosis Association.

The Sumter County Medical Society has elected Dr. John M. Rhame president.

Cherokee County is planning construction of a 101 bed hospital.

After an absence of 38 years, Dr. R. A. Allgood has returned to practice in Pickens.

Chester County Medical Society held its first annual Medical Assembly in November.

Dr. Rudolph Farmer has been elected assistant-superintendent and Medical director of the South Carolina Sanatorium at State Park. Dr. Wm. H. Moncrief, superintendent, will retire in June 1954.

Dr. Robert Brownlee has returned to pediatric practice in Greenville.

Dr. Norris Hines is the new anaesthesiologist at the Anderson Memorial Hospital.

Dr. Morgan Milford has opened offices for the practice of surgery in Greenville.

Dr. James R. Young, of Anderson, has been re-elected a director of the American Cancer Society.

Dr. Edwin Miller has joined the staff of the McIlwain Clinic in Belton.

The Ninth District Medical Association held its annual meeting in Union in November. Discussions centered about infant mortality. Dr. Bray of Columbia spoke on Anaesthesia, and an address was made by Dr. John Cuttino of Charleston.

Dr. Robert T. P. de Treville, formerly of Charleston, now captain in the air force, was married to Miss Janice Suzanne Mundy on November 26 in Washington.

The South Carolina Medical Association was represented at the December meeting of the American Medical Association in St. Louis by Drs. William Weston, Jr., Dr. Robert Wilson, Dr. Julian Price, and Dr. C. R. F. Baker.

DEATHS

J. R. EDENFIELD

Dr. J. R. Edenfield died suddenly on Nov. 25, 1953. Dr. Edenfield, born and reared in North Augusta, was graduated from Furman University in 1939, was graduated from the Medical College of South Carolina. He interned at Roper Hospital at Charleston, entered the United States Navy as a lieutenant in the medical corps in 1944 and served in the South Pacific until 1946. After he came out of the navy he was associated with Dr. F. E. Kennedy in the practice of medicine. In 1949, he began a separate practice in Horse Creek Valley in Aiken County. He was a member of the Aiken County Medical Society, the North Augusta Baptist church and the American Legion Post No. 77, Graniteville. He has served on the staff of the Aiken County Hospital.

GEORGE HENRY ZERBST

Dr. George Henry Zerbst of Columbia died on November 21, 1953.

He was born in Charleston, a son of George Henry and Marion Grumme Zerbst. He attended Charleston High School and was graduated from Clemson College and the Medical College of South Carolina.

He interned at Episcopal Hospital, Washington, and for a time was surgeon for the Southern Pacific Railroad. He returned to Charleston where he engaged in practice for a number of years.

Dr. Zerbst then became county health officer for the State Board of Health, serving in Sumter, Lee and Lexington Counties. He also served as director of the Division of Industrial Health for the State Health Board.

Because of ill health, he retired from active practice a few years ago. During part of the time after his retirement, however he worked with the Veterans Rating Board.

BOOK REVIEWS

Physical Examination of the Surgical Patient, J. E. Dunphy and T. W. Botsford, W. B. Saunders Company, Philadelphia. Price \$7.50.

This is a fine and complete manual of how to go about using one's five senses in finding out what is wrong with the surgical patient. It is a salutary recall to the fundamental principle that the doctor's chief tools are his "eyes, ears, fingers, nose and brain." Neglect of these with dependence on a multitude of laboratory procedures is an all too frequent failing in practice today.

The book is well-illustrated mostly with simplified line drawings, some of which are from Homans' classic Textbook of Surgery. But it is completely up-to-date, including, for example, the methods of obtaining smears for exfoliative cytology. The section on the examination of the acutely injured patient should be read by all physicians dealing with trauma. The index is adequate and there is a short bibliography which is useful as a reading list for the student. All physicians will find this volume equal to a post-graduate course in surgical diagnosis.

F. E. Kredel, M. D.

Anatomy and Surgery of Hernia, L. M. Zimmermann and B. S. Anson, Williams and Wilkins Company, Baltimore. Price \$10.00.

This is a useful and informative volume for physicians concerned with the various types of hernia. While one might quarrel with the blurb of the publisher on the jacket that it contains "complete directions for the successful management of every type of abdominal hernia," one is assured by the authors in their preface that "full clarity still remains an elusive prize.

Emphasis is placed on the anatomical factors of the various herniations and these are well-illustrated by anatomical drawings. Each chapter concludes with well-chosen references to the literature. While most of the book is concerned with inguinal and femoral hernia, there are also chapters on the other types of abdominal herniations less commonly encountered.

The concluding chapter is devoted to the controversial problems of the medico-legal aspects of inguinal hernia. While noting that anatomical factors involving congenital predisposition are present in all inguinal hernias, direct as well as indirect, they conclude that one cannot deny the possibility of trauma. In the form of sudden and excessive abdominal pressure, resulting in overt hernia. They emphasize the difficulty of establishing long duration of the hernia, ante-dating an alleged accident, by clinical and operative findings.

F. E. Kredel, M. D.

Clinical Management of Behavior Disorders in Children, Harry Bakwin and Ruth Morris Bakwin—Philadelphia and London (W. B. Saunders Co.) 1953—Price \$10.00.

This is a new book, not a new edition of the book on Psychological Care published by these authors in 1942. It has the great virtue of having experienced practical pediatricians as authors, rather than the usual type of people who write on such subjects. Hence perhaps, it has a refreshing atmosphere of practical observation in those varied circumstances in which practicing physicians find themselves. Without wearing out the word, let us say that this is a practical guide with ample description of practical tools.

There are chapters on growth and development, and a critical evaluation of data, all in simple language which avoids the vagueness of many other writers.

There is found here a very sane approach to mental testing, which is regarded with a dubious eye and discouraged except when specific indications exist. Consideration is given to a wide variety of subjects such as rooming-in, hospital care of children, sex-instruction and the importance of parents in hospital care. There is detailed discussion of the behavior side of many specific diseases.

This is a book which could well be added to the shelf of the student or the practitioner who deals in any way with children.

J. I. W.

Peripheral Nerve Injuries—The Principles of Diagnosis, by Webb Haymaker, M. D. Chief, Neuro-pathology, Armed Forces Institute of Pathology, Washington, D. C. and Barnes Woodhall, M. D., Professor of Neurosurgery, Duke School of Medicine, Durham, North Carolina.

In this second edition the book has been vastly improved. Standard works are consulted, and the illustrative materials from Foerster, Tinel, Pollock and Davis, and Kinnier Wilson are used with care and discretion. The subject matter is divided into four sections, the first dealing with the principles of innervation, the second with examination of the patient, the third with a clinicopathological classification of the peripheral nerve injuries, and the general symptomatology of such injuries, and the fourth with the clinical features of individual plexuses and the peripheral nerve injuries.

After a quick and accurate survey of the peripheral nervous system, examination of the motor functions of the body with strict adherence to the part peripheral nerves play, is taken up. Throughout, pertinent illustrations play a prominent part.

There follows classification of the causes of peripheral nerve injuries, and finally the injuries themselves.

There are few books in which the object is more directly approached, and the subject treated more succinctly. Here is a book to be kept at the reader's elbow and frequently consulted.

SPARTANBURG COUNTY MEDICAL SOCIETY ELECTS NEW OFFICERS

The following are the newly elected officers for the year 1954.

President—Dr. Charles H. Poole
Vice President—Dr. James G. Jeanes
Secretary—Dr. Richard Wilson
Treasurer—Dr. E. M. Colvin

Delegates To State Meeting:
Dr. Fred Adams (Beginning Jan. 1954)
has 4 years to serve
Dr. W. A. Wallace (Beginning Jan. 1954)
has 3 years to serve
Dr. W. C. Herbert (Beginning Jan. 1954)
has 2 years to serve
Dr. D. C. Alford (Beginning Jan. 1954)
has 1 year to serve

Board Of Censors:
Dr. A. K. Temples—Chairman (1 year to serve)
beginning Jan. 1954
Dr. Avery Phifer—(2 years to serve)
beginning Jan. 1954
Dr. J. C. Josev—(3 years to serve)
beginning Jan. 1954

Dr. Robert D. Hill was voted by secret ballot the Annual Doctor Of The Year Award 1953 for Spartanburg County. The Annual December Dinner Dance was held on December 11, 1953.

George W. Price, M. D.
President

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

HEALTH AND ACCIDENT INSURANCE STUDIED

One of the most interesting and informative meetings of the Pee Dee Medical Society was that held on the evening of Thursday, December 17, at Dillon. The speaker was Senator W. P. Baskin of Bishopville, who discussed the subject of health and accident insurance in relation to present laws in South Carolina.

Senator Baskin, who is completing his fourth four-year term as State Senator from Lee County, has been prominent for a number of years in the legislative and political circles of the State. Serving first as vice-chairman of the Senate Committee on Medical Affairs, he later became Chairman, and has held that post for several years. In this capacity, Senator Baskin has been closely related to medically connected legislation, both that proposed and enacted in the State. He has been consistently on the side of constructive legislation and has proved on more than one occasion, his friendship to the medical profession. He occupies the unique position of being the only lawyer on the Board of Trustees of the Medical College of South Carolina, a position held by virtue of his office as Chairman of the Senate Committee on Medical Affairs.

The insurance law of the State has been a matter of special interest to Senator Baskin. He headed the Joint Legislative Committee which after a lengthy study and investigation of the existing statutes, re-codified the entire insurance law of South Carolina within the past few years. The result was a remarkable improvement in the statement and the effect of the provisions of the insurance law.

Senator Baskin now heads a Committee composed of members of the Senate and the House of Representatives, engaged in studying the situation in the State with reference to health and accident insurance. The scope of the investigation includes an inquiry into the financial responsibility, reputation, and general standing of the companies selling this type of insurance, the provisions of the policies, the rates of premiums charged, and the methods being employed in dispensing the coverage. Senator Baskin pointed out that while life and fire insurance, and various other types of casualty coverage, have long since been standardized and, with rare exceptions, most companies in these fields and their contracts may be regarded as reliable, health and accident insurance is comparatively new. In this section of the country, particularly, it was introduced within the past few years, and its growth has been remarkable and rapid. It is, nevertheless, still a matter of experimentation and a tempting object of speculation on the part of promotionally-minded people who think they see in the field an opportunity for quick money. It is inevitable, therefore, that some unreliable contracts will be

placed on the market, and that not every company selling accident, health and hospital insurance can be recommended.

The situation has long been recognized by members of the legal and medical professions. Too many members of both have had the experience of being forced to tell clients or patients, after the loss has occurred, that the protection which they thought they had bought and paid for, actually did not exist. The Legislature is to be commended for taking the initiative in the effort to clean up the situation, and in the manner in which it appears to be proceeding—i.e., through careful, impartial, and thoughtful investigation with respect to the various companies licensed to sell this type of insurance and the provisions of the contracts that are being offered in South Carolina.

Senator Baskin pointed out several phases of the subject which are receiving special attention and which must be carefully regulated in order to bring about a desirable situation with respect to this type of insurance. Among them were: the pay of the agents; misleading advertising, and the use of statements calculated to mislead the unwary into the belief that a broader and more complete coverage is offered than is actually revealed by the language of the policy; exceptions (the practice of including in less prominent wording and position, conditions and ailments which are excepted from the general provisions of the policy emphasized in the more conspicuous wording); contestability; and the grace period. With life insurance contracts there is a uniform grace period of thirty days, regulated by law in South Carolina. This does not apply to health and accident insurance and, with rare exceptions, no grace period is allowed for the payment of premiums on these contracts. The contestability feature likewise is different. Most life insurance contracts are incontestable after a period of two years. With health and accident policies, however, no such standard exists. After having paid for health insurance over a long period of years, the individual may find when he applies for benefits, that he is up against the claim that some false or erroneous statement given at the time the application was made, renders the contract void. A limited time fixed in the policy, within which the insurance company might take advantage of such defenses should be provided.

Senator Baskin said that his Committee, along with agencies of several other states, is looking into the possibility of adopting a uniform health and accident insurance policy law—one that would apply to the states in general, and as a result of which, complete standardization in this field doubtless would be reached much more quickly than without it.

Pointing out that 360,000 people in South Carolina,

approximately one-sixth of its population, have hospital or health insurance of some kind, and that the number is growing rapidly, the Senator emphasized the necessity of proper legislative regulation of the business and the urgent need for full cooperation by the medical profession in the effort. It was estimated that perhaps 25% of those insured have coverage which is actually inadequate.

A round-table discussion followed Senator Baskin's talk—a discussion which was participated in generally by the members present, and which proceeded in a spirited and interesting vein. A similar discussion by Senator Baskin, or some other member of his Committee, before other county societies would, undoubtedly, prove highly interesting and profitable.

It was the consensus of opinion, expressed forcibly by several of the physicians, that in order to work out a satisfactory situation and to bring about the type of insurance coverage in this field which is desirable, the medical profession needs to police itself—that there is much that should be done by some of its own members to correct undesirable situations which lead to false impressions and dissatisfaction by holders of health and accident insurance.

A. M. A. HOUSE OF DELEGATES IN INTERIM SESSION

The House of Delegates of the American Medical Association, meeting at the Jefferson Hotel in St. Louis during the Seventh Annual Clinical Session, took important policy actions on social security, voluntary health insurance, medical ethics and unethical practices, medical education, hospital accreditation, military affairs and a wide variety of subjects affecting both physicians and the public.

Approving a recommendation by its Reference Committee on Legislation and Public Relations, the House passed a resolution reaffirming its opposition to the compulsory coverage of physicians under the Old Age and Survivors Insurance provisions of the Social Security Act and advocating passage of the Jenkins-Keogh bills now pending in Congress. These bills were described as providing for "the development of a voluntary pension program which is equitable, free from compulsion, and satisfies the retirement needs of physicians."

The reference committee report adopted by the House said:

"The purpose of these bills is to eliminate the discrimination, and inequities which exist under present tax laws by extending the tax deferment privilege to the country's ten million self-employed and also to millions of employees who are not covered by pension plans. The purpose of the resolution is to reaffirm our support of the voluntary pension program provided in the Jenkins-Keogh bills and to reaffirm our strong opposition to the extension of compulsory coverage of physicians and other self-employed persons under Title II of the Social Security Act."

The same committee report urged continued action to obtain passage of the Bricker Amendment (S. J. Res. 1) and approved the principle of legislation

which would reduce or remove the limitation on the deduction of medical and dental expenses for income tax purposes. It also opposed any further extension of the "Doctor Draft" Law beyond the present expiration date of June 30, 1955.

The report said that "your Committee feels strongly that there should be no further extension of the 'Doctor Draft' Law. We feel that the legislation is discriminatory and urge the Committee on Legislation and the Board of Trustees to actively oppose any further extension."

The House acted to accelerate the development of voluntary health insurance by passing a resolution requesting the Council on Medical Service to proceed immediately with a special study of the problems of catastrophic coverage and coverage for retired persons. The Council was asked to present its findings and recommendations to the House not later than the 1954 Clinical Meeting. The resolution pointed out:

"There are two large groups of citizens for whom improved coverage could be offered under present prepaid medical care plans, namely: (a) those individuals who suffer catastrophic or long-continued and highly expensive illness and whose financial resources are not adequate to meet the cost thereof and (b) those citizens who have retired and are living on small incomes and who are not eligible under presently existing public or private plans."

The resolution emphasized the medical profession's "responsibility to make every effort to promote such prepaid medical coverage for all citizens whose circumstances make them eligible."

Another resolution on voluntary health insurance, adjudged to be emergency business by the Reference Committee on Insurance and Medical Service, condemns all insurance contracts which classify any medical service as a hospital service." The resolution reaffirmed previous actions of the House defining pathology, radiology, anesthesiology and psychiatry as medical services.

A second emergency resolution, which would have endorsed the principle of federally subsidized scholarships for prospective military personnel in order to encourage the building up of a career-basis medical corps for the armed forces, was referred by the House to the Board of Trustees for study and action.

A resolution introduced by the Iowa State Medical Society, calling for approval of a joint-billing procedure involving services rendered by two or more physicians, was referred to the Judicial Council, at the suggestion of the Reference Committee on Miscellaneous Business, with the recommendation "that the Judicial Council investigate the factors involved in the matter as presented and determine if there are new factors or new facets that would cause it to change the opinion" determined in 1952.

The House approved a revision of one section of the Principles of Medical Ethics of the A. M. A., which clarifies the relationship of physicians to all forms of public information media. The revision had

been worked out by the Council on Constitution and Bylaws.

In an effort to solve the publicity problems resulting from unethical practices by a small minority of doctors, the House referred to the Board of Trustees a resolution calling for appointment of a special committee with broad professional representation to study all aspects of the problems. The Board was asked to study and implement the intent of the resolution and to report its findings to the House at the June, 1954, meeting in San Francisco.

To clarify misunderstandings among physicians regarding the rules and regulations of the Joint Commission on Accreditation of Hospitals, especially as they concern the role of the Department of General Practice in a hospital, the House adopted the following resolution:

"That this House of Delegates urges the Journal of the American Medical Association and other official publications circulating among the medical and hospital professions, to acquaint the medical-hospital profession with the regulations, bylaws and their interpretations, and

"That the Commission clarify the methods by which an aggrieved hospital or its staff may appeal a decision with which they are not in agreement."

In the field of medical education the House was "pleased to note" that a fourth grant of \$500,000 had been made by the American Medical Association to the American Medical Education Foundation for financial aid to the nation's medical schools. The Foundation reported that its 1953 income now totals \$1,174,000 and that the number of contributors now is more than double the total in 1952.

At the opening session of the House, Dr. McCormick in his presidential address made a strong appeal to the nation's physicians for "action that will further the full confidence of the public in our profession."

"Good public opinion cannot be bought," he declared. "It must be earned through exemplary conduct and genuine service in the public interest. Whatever money the A. M. A. and its constituent societies spend for public education and public relations is wasted unless individual physicians take wholehearted interest in assuring the success of these ventures."

GENERAL PRACTICE AND MEDICAL RESEARCH

Dr. William B. Bean, one of the speakers at the recent scientific session of the American Medical Association, held in St. Louis the early part of December, voiced a sharp protest against practicing medicine "in swarms" and "research by caucus." He emphasized that general practice is the best field for medical research.

According to a report of his address as carried in the St. Louis Globe-Democrat of Wednesday, December 2, Dr. Bean, who is head of the Department of Medicine at the University of Iowa, Iowa City, "warned medical researchers that they are getting so far away from human beings as a subject of study that they are in danger of treating them as 'dry ab-

stractions.'"

The newspaper account reported Dr. Bean as illustrating his point by the failure of the medical profession to solve the riddle of insomnia despite extensive research.

"The place to get more facts" according to Dr. Bean, as reported by the St. Louis paper, "is in the busy life of medical practice, the observation on patients, on family and on self. Researchers of our present day so often follow the template of technique—so that much of what passes for investigation is the mechanical echo of a method. Thus the results may become the routine accumulations of pedestrianism, not illuminated by ideas.

"Perhaps the simplicity of the complaints (of patients) is unfashionable, but we owe them the courtesy of attentive thought. It takes no atom-smasher, to come to grips with the problem—but it does take time and thought."

Dr. Bean pointed out that the necessary clues to answers to medical problems are not likely to come from 'peep-show specialists' and that the belief is growing in some quarters that the thoughtful physician who employs his time in concentrated observation of the sick may eventually provide the 'flash of insight' necessary for the solution of many medical problems.

"There is real danger," Dr. Bean said, "that our patient may disappear as an entity, John Smith, and become in fact that dry abstraction, the common man, whose conception is presided over by a 'conceptionist,' his birth attended by an obstetrician, his early days spent in the hands of a pediatrician, whose burst into adult life is in the hands of an 'adolescentist,' and who during life is buffeted about by all the 'icians' and 'ists.'

"At length, he begins to become unstrung under the careful guidance of a 'climacterician,' and finally the shriveling atrophy of old age is lubricated by the attention of a geriatrician, until bedeviled, bewildered and bemused, he falls exhausted off the end of the conveyor belt into the hands of the mortician."

Despite his partly humorous and in some instances rather caustic remarks about the methods and results of research by specialists, Dr. Bean concluded by saying:

"In no sense are these remarks anti-scientific and I bow my head in awe and humility before the magnificent structure of modern science."

BILL FOR AID TO HEALTH PLANS

A health insurance bill to provide Federal and State grants to assist voluntary non-profit prepayment health plans was introduced in both houses of Congress at the last session, by Senators Ives and Flanders and Representatives Javits, Hale and Scott. According to a report by the Research Council for Economic Security, "The plan provides that the premium for insurance be based on a percentage of the income of the insured with Federal and State grants-in-aid making up the difference between the standard pre-

mium and what the individual can afford to pay. The bill also places primary responsibility for the development of adequate health services with the states, local communities, non-profit health plans and the medical profession. Mr. Javits supported his argument for the bill by stating that a survey made by the University of Michigan Survey Research Center for the Federal Reserve Board revealed that nearly one-third of the 15 million families in which the head is less than 45 years of age and where the children are under 18 owe medical bills. According to this source, of all the money spent privately for medical care in the U. S., about \$1 out of every \$9 remains as a debt to a doctor, hospital or pharmacist. This condition exists despite the fact that more than half of the nation's population has some sort of insurance coverage against sickness.

AMERICAN COLLEGE OF SURGEONS

All members of the medical profession are invited to attend an information-packed Sectional Meeting of the American College of Surgeons to be held at the Hotel Charlotte in Charlotte, North Carolina, February 1 through 3.

The ACS policy of disseminating information about new methods and therapies to improve surgical standards continues as important to the College today as it was back in 1913 when the organization was founded for this purpose. Hence, although the meeting is designed for surgeons, it is open to all related fields with no restriction on attendance from outside the area. This meeting is the first of six scheduled for various parts of the United States, Canada, and London, England, from February through May.

Dr. Thomas D. Sparrow will preside over the opening morning session, February 1, when Dr. Alfred Blalock of Baltimore will speak on Certain Aspects of Cardiovascular Surgery. A symposium on Trauma will follow, with William G. Whitaker, Jr., Atlanta, speaking on Injuries to Blood Vessels, Joseph R. Shaeffer, Washington, D. C., on Plasma Expanders, and Frank K. Kanthak, Atlanta, on Maxillofacial Injuries.

Dr. Joseph M. Donald, Birmingham, will preside over the two afternoon panel discussions. The first, on Jaundice, will have Nathan A. Womaek, Chapel Hill, as moderator and, as collaborators, Raymond M. Wheeler, Charlotte, Deryl Hart, Durham, and C. Frank Chinn, Tampa. The second panel, on Nutrition in Surgery and Pre- and Postoperative Care in the Aged, will have as moderator Isaac A. Bigger, Richmond, and, as collaborators, F. E. Kredel, Charleston, George D. Lilly, Miami, and John D. Martin, Jr., Emory University.

Fred W. Rankin, President of the American College of Surgeons, and Paul R. Hawkey, The Director, will speak at the official dinner on Monday evening. A symposium on Cancer will follow, with John C. Burch, Nashville, presiding. Speakers are James S. Krieger, Cleveland Clinic, "The Place of Surgery in Treatment of Uterine Malignancy," S. A. Wilkins, Jr., Emory University, "Cancer of the Larynx and Pharynx" and Danely P. Slaughter, Chicago, "Diagnosis of Accessible Cancer."

Dr. Hamilton McKay, Charlotte, will preside over the morning session on the second day. Speakers and papers follow:

Injuries to the Elbow. Thomas B. Quigley, Boston.
Acute Surgical Lesions of the Intestine. Hilger P. Jenkins, Chicago.
Thrombosis and Embolism. Alton Ochsner, New Orleans.

Diagnosis and Management of the Mediastinal Tumors. H. H. Bradshaw, Winston-Salem.
ACTH and Cortisone in Surgery. Brock E. Brush, Detroit.

Dr. Alfred P. Jones, Roanoke, will preside over the afternoon meeting:

Radical Versus Simple Mastectomy for Carcinoma. George G. Finney, Baltimore.

Unnecessary Pelvic Surgery. Robert A. Ross, Chapel Hill.

Management of Surgical Disease Occurring During Pregnancy. John C. Burch, Nashville.

Panel Discussion—Internal Fixation of Fractures

Moderator: Peter B. Wright, Augusta.

Collaborators: Julian E. Jacobs, Charlotte, H. Page Mauck, Richmond.

A motion picture symposium will be held Tuesday evening, beginning 8:30 p. m., featuring Cine Clinic films recently shown at the Clinical Congress. The program will include the following films:

Obstruction of Small Intestine. Charles G. Johnston, Detroit, and Rudolph J. Noer, Louisville.

Pneumectomy for Carcinoma. William E. Adams, Chicago. This film has been dedicated to Evarts A. Graham, originator of this procedure.

Surgical Treatment of Diverticulitis of the Sigmoid. R. Kennedy Gilchrist, Chicago.

Pancreatic Cysts. Charles B. Puestow, Chicago.

The Tennessee Chapter of the American College of Surgeons will present the program on the final day, February 3. Charles D. Blassingame, Memphis, will preside over the morning program:

Cysts of Pancreas—Etiology and Treatment. John E. Kesterson, Knoxville.

Multiple Primary Carcinomata of the Colon. Edward T. Newell, Jr., Chattanooga, coauthor, Cecil E. Newell.

Vagotomy and Antrectomy in the Surgical Treatment of Duodenal Ulcer. Leonard W. Edwards, Nashville, President of the Tennessee Chapter.

Hypothermia in Cardiac Surgery. H. William Scott, Jr., Nashville.

Massive Hemangiomas of the Liver—Diagnosis and Treatment. Harwell Wilson, Memphis.

Acute Abdominal Emergencies in Infancy and Early Childhood. Clarence E. Gillespie, Memphis.

Dr. William H. Sprunt, Winston-Salem, will preside over the afternoon's clinicopathology conferences. Dr. Paul Kimmelstiel, Charlotte, will select two problem cases for conference and work-up of protocols. There will be audience participation, and results of the complete case with the final diagnosis by Dr. Kimmelstiel. Alton Ochsner, New Orleans, will discuss Case 1 and, for Case 2 participants will be Thomas W. Goodwin, Augusta, and Leonard W. Edwards, Nashville.

Medical motion pictures and Cine Clinic films will be shown each morning of the meeting. Among the films to be shown are the following:

Fractures of the Humerus. Veterans Administration. Washington, D. C., William A. Larmon, Chicago.
Tendon Injuries. Michael L. Mason, Chicago.

Otoscopic Cinematography of the Tympanic Membrane and Middle Ear. Paul H. Holinger, and Kenneth C. Johnston, Chicago.

Surgery of the Aged. Erwin R. Schmidt, Madison.

Intestinal Obstruction Due to Ascaris Lumbricoides. Hilger P. Jenkins and Daniel J. Pachman, Chicago.

Abnormalities of the Extrahepatic Biliary Ductal System. I. S. Ravdin, Philadelphia.

Ovarian Tumors. Herbert E. Schmitz, Chicago.

Further information about this meeting or other Sectional Meetings may be obtained from Dr. H. Prather Saunders, Associate Director, The American College of Surgeons, 40 East Erie Street, Chicago 11, Illinois.

The Problem of Nausea and Vomiting:

ITS TREATMENT WITH DRAMAMINE®

Whenever nausea, vomiting and vertigo are disturbing and complicating factors, Dramamine may be used with confidence.

Keats¹ outlines the wide list of conditions in which Dramamine (brand of dimenhydrinate) has proved valuable as follows: "It has been well established in the control of motion sickness. It has been used effectively in the prevention and treatment of seasickness, airsickness, [in the treatment of] the nausea of pregnancy, Ménière's syndrome, . . . radiation sickness . . . and postfenestration reactions. . . . The site of action is imperfectly understood, but there is indication of an action of depressing labyrinthine function or its neural pathways, a highly selective central action, or both. Few side reactions of this drug have been noted."

The usual dose for motion sickness is 50 mg. (one tablet) taken one-half hour before departure and, if necessary, before meals for the duration of the journey. Control of nausea and vomiting of other conditions and severe motion sickness is achieved, with minimal drowsiness, by a dosage of 100 mg. every four hours.

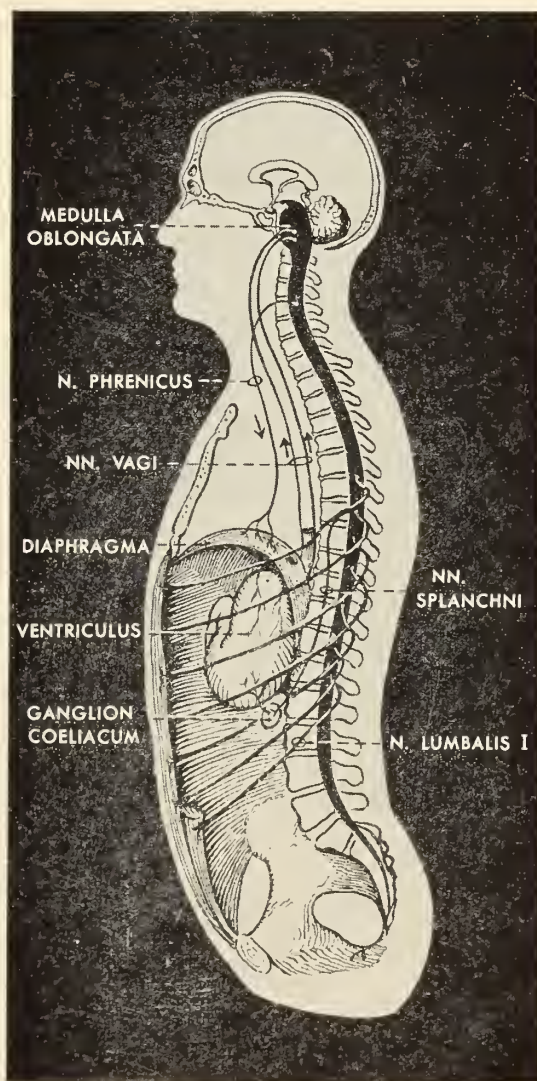
"[Dramamine] is administered orally or rectally. . . . The same doses may be administered rectally by insertion of the tablet or other suitable form. . . ."²

Dramamine Liquid is particularly useful for children.

Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

1. Keats, S.: Ataxic Cerebral Palsy with Akinetie Seizures: Dramatic Response to Dramamine, J. M. Soc. New Jersey 50:53 (Feb.) 1953.

2. Council on Pharmacy and Chemistry: New and Nonofficial Remedies, 1953, Philadelphia, J. B. Lippincott Company, 1953, p. 471.



THE VOMITING REFLEX: *Vagus*→*nodose ganglion*→*solitary tract*→*spinal cord*→*cervical, thoracic and lumbar nerves* to *diaphragm, cardiac sphincter, stomach, abdominal and pelvic musculature*. (After Krieg, W. J. S.: *Functional Neuroanatomy*, ed. 2, New York, The Blakiston Company, Inc., 1953, p. 104.)

SEARLE *Research in the Service of Medicine*

HEAL THYSELF

The public always appear surprised that doctors should fall ill, as though hearing that a policeman's house had been burgled or the fire station had gone up in flames. Doctors go sick fairly often, though they suffer differently from anyone else: they have only one disease, which presents both a *mitis* and a *gravis* form.

The *mitis* phase is characterized clinically by the usual symptoms of malaise, headache, shivering, loss of appetite, coughing, and insomnia. It usually lasts several days, while the doctor does his surgery sitting in an overcoat and wonders why he's becoming so bad-tempered. He shakes off his symptoms like a wet dog and makes a diagnosis of draughts, late nights, or over-work.

When he wakes up one morning with black shapes in front of his eyes he sneaks down to the surgery in his dressing-gown and stealthily takes his temperature. A hundred and four! This immediately ushers in the *gravis* stage of the illness. He snatches a textbook from the shelf and nervously flicks over the pages. The first disease he spots is typhoid fever. *Prostration . . . headache . . . cough . . . backache . . .* he reads, running his finger quickly along the symptomatology. He realizes nervously he has every one of these afflictions, locks the door, and tries to feel his own spleen.

Admitting he is a desperately ill man he staggers to bed, bringing with him every medical and surgical textbook he can lay hands on. Once comfortable on the pillows he can see the problems of diagnosis more clearly. There are several more alarming diseases than typhoid to attract him, and after a while he becomes certain he is in the grip of either cholera, smallpox, or plague. He takes his pulse, inspects his tongue in his wife's hand-mirror, and carries out a careful search of his entire body-surface for spots. Finally he settles for malignant endocarditis, a diagnosis that in his finals would have had him thrown out of the examination room.

He next faces the problem of treatment. Doctors' houses are well supplied with drugs by the manufacturing chemists, who supplement their advertisements in the morning mail with transparently-wrapped packets of samples. These are always stuffed into the bathroom cabinet where old tooth-paste tubes, rusty razor blades, and worn fragments of soap accumulate. Dragging himself out of bed, he finds a bottle of bright green pills and wonders what they are. He swallows a few and rummages about until he comes across some aspirins. Several more colored packets then attract him, and he starts mixing himself a therapeutic *hors d'oeuvre*.

Doctors require different doses from the general public. The patient who goes away with a prescription marked sternly ONE TEASPOONFUL IN AN EGG-CUPFUL OF WATER EVERY FOUR HOURS is frightened enough to assemble spoon, egg-cup, and kitchen clock and takes the dose as precisely as starting a race. But in the profession pills are generally taken in doses of ONE HANDFUL NOW AND THEN (or if they are partieu-

larly small ones, ABOUT A DOZEN), medicine administered as A LARGE SWIG PRETTY FREQUENTLY, and ointment and embrocations assumedly labelled RUB ON VIGOROUSLY UNTIL ALARMED BY THE CONDITION OF THE SKIN.

The doctor's wife, who has recognized for some days that he is suffering from 'flu, suggests she summon one of his colleagues. But doctors, like animals, prefer to be ill alone. He refuses to see anyone; and when she insists on telephoning a rival practitioner the consultation is usually embarrassing and unhelpful:

"Why, hello, Bill! Laid up, eh? Been taking your own prescriptions, ha ha!"

"Hello, George! Decent of you to come. Needn't bother about the old bedside manner in the trade, eh, ha ha!"

"What's the matter with you Bill?" asks the visiting doctor.

"Well, I think I've got polyarteritis nodosa, or possibly methemoglobinaemia."

"Go on!"

"Yes. What symptoms should I have?"

"Oh, sort of pains in the limbs and so on."

"That's it exactly!"

"Well, I hope you get better."

"Yes, so do I. So kind of you to come along professionally like this. Good-bye."

Doctors recover in a different way from ordinary people. A layman is told to stay in bed for an extra week, and take a fortnight at the seaside; but a doctor, after taking his temperature every half-hour for a day or so, suddenly discovers he is completely cured. He at once gets up and puts on his clothes, and either goes downstairs and takes the evening surgery or makes for the garden to catch up with his digging. As most doctors will admit, they can't afford to be ill: they're not registered as patients under the National Health Service.

RICHARD GORDON

Reproduced by permission of the Proprietors of *Punch* (London)

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

South Carolina Medical Association

1953-1954

C. R. F. Baker, M.D.	Sumter	President
George Dean Johnson, M.D.	Spartanburg	Vice President
Thomas R. Gaines, M.D.	Anderson	President-Elect
Robert Wilson, Jr., M.D.	Charleston	Secretary
J. Howard Stokes, M.D.	Florence	Treasurer
M. L. Meadors	Florence	Executive Secretary and Counsel
Joseph I. Waring, M.D.	Charleston	Editor of Journal
Mrs. Claude G. Watson	Fifth District	Business Manager of Journal

DELEGATES TO A. M. A.

William Weston, Jr., M.D.	Columbia
Julian P. Price, M.D.	Florence

COUNCILORS

First District (Charleston, Colleton, Jasper, Dorchester, Berkeley, Beaufort)		
J. W. Chapman, M.D.	Walterboro, S. C.	
Second District (Edgefield, Aiken, Lexington, Richland, Saluda)		
O. B. Mayer, M.D., Chairman	Columbia, S. C.	
Third District (Laurens, Newberry, Greenwood, Abbeville, McCormick)		
H. B. Morgan, M.D.	Ware Shoals, S. C.	
Fourth District (Anderson, Greenville, Oconee, Pickens)		
Chas. N. Wyatt, M.D.	Greenville	
Fifth District (Chester, Kershaw, Lancaster, York, Fairfield)		
R. L. Crawford, M.D.	Lancaster	
Sixth District (Florence, Darlington, Chesterfield, Marlboro, Dillon, Marion, Horry)		
J. P. Cain, M.D.	Mullins	
Seventh District (Clarendon, Georgetown, Lee, Sumter, Williamsburg)		
A. C. Bozard, M.D.	Manning	
Eighth District (Allendale, Bamberg, Barnwell, Calhoun, Hampton, Orangeburg)		
J. H. Gressette, M.D.	Orangeburg	
Ninth District (Spartanburg, Union, Cherokee)		
D. L. Smith, M.D.	Spartanburg, S. C.	

The Journal of the South Carolina Medical Association

VOLUME L

February, 1954

NUMBER 2

*The Importance of the Family Doctor in Psychotherapy**

RALPH R. COLEMAN, M. D.

Charleston, S. C.

I was prompted to choose my topic because of recent experiences in attempting to secure an associate. I sought help through the various medical bureaus. There were hundreds of listings of well trained, well qualified internists looking for opportunities to affiliate in practice. Most of them listed some particular special interest or sub-specialty. There were men interested in cardiology, allergy, gastroenterology, diseases of the chest, and so on. I could not, however, find an internist with an interest in psychiatry. Moreover, in the many interviews that followed, I found no one interested in the human side of medical practice, very few interested in comprehensive medicine—the appreciation of the patient as a person. Most of my applicants actually expressed a distaste at the prospect of handling the neurotic patient, or expressed feelings of inadequacy as to their skill in being able to do so. I had the impression that they would like to “skim the cream” of clinically interesting patients and to somehow dispose of the more neurotic or complaining patients. Some grudgingly admitted that they would be willing to take care of a few of these people, but only from necessity and not from choice, and not out of sympathetic interest in this type of person. It seemed to me that these doctors and many others that you and I know have built up neurotic defenses against a particular aspect of medical care. It may be that “group

inferiority feelings” on the part of physicians may be responsible for their reluctance to investigate or to attempt to treat a patient’s emotional problems.

With rapid scientific advances our knowledge of etiology of disease has led us to standardization of treatment. The management of these diseases of known etiology can thus easily be learned. The knowledge of which drug to use is seldom a difficult skill for a doctor to acquire. Today doctors handle disease competently.

Unfortunately I cannot say that doctors always handle patients as competently. Here we enter a field in which there is little standardization and seldom any formal training.

The growth of the various specialty boards, necessary as they were to establish high standards of training and professional specialized skills, resulted inevitably in a shift of emphasis away from the patient. This was necessary if limited special interests were to be studied intensively and special skills were to be acquired. The desire of doctors to limit their endeavors to a particular specialty or sub-specialty may also result in limiting their usefulness. The more specialized a doctor’s training becomes, the greater the opportunity for him to develop distortions in his point of view. Each doctor views his patient from a different perspective.

The orthopedist sees the patient with a shorter leg and thinks in terms of surgical treatment or a special shoe or appliance, the internist with interest in metabolic disease may

* Presented before the Postgraduate Seminar of the Medical College of South Carolina November 3, 1953.

be thinking in terms of whether the patient could have a rare case of hyperparathyroidism, the psychiatrist may think of how his interpersonal relationships may be modified by his crippling deformity. Each point of view is necessary, but comprehensive medicine must encompass them all.

The emphasis has too long been placed on diagnosis rather than on treatment. A danger which a patient risks today when he consults a physician is the danger of being given a diagnosis. Patients must not be "pigeon holed." Too often patients are run through "assembly line" diagnostic mills, are seen by seven different specialists, come out with fourteen different diagnoses and often with conflicting recommendations for treatment. Patients cannot be "sliced up" according to medical specialties and cannot be treated as a collection of diseases. Every specialist has his limitations and the more specialized a specialist he is, the greater his limitations become. The ophthalmologist would have his blind spot about the management of diet in his diabetic with cataracts, the orthopedist is "crippled" in that he may not be able to see that his patient with multiple fractures needs a will to live and the psychiatrist may himself lack the "insight" to see that the symptoms he blamed on environmental stresses were really the result of a metabolic disorder and so on. The more comprehensive our view point, the better job we can do in helping the sick.

The revival of the concept of *psychosomatic medicine* in recent years has been helpful in a reorientation of physicians as to their aims in the practice of medicine. It is not a specialty but a point of view. Unfortunately the term has become another label, and we now hear of varying ailments of uncertain etiology such as ulcerative colitis, migraine, peptic ulcer, and obesity being labelled as "psychosomatic." By the same mistake, we can label "somato-psychic" all of the disorders of the emotions arising from organic or chemical disease such as uremia, hypoglycemia, small strokes, brain tumor, febrile delirium, and the like.

To my mind what psychosomatic medicine should represent is the point of view that we again recognize that the patient is not a collection of organs or diseases in one housing,

but a complex, integrated psychological as well as physiological and anatomical entity subject to daily stress and constant change. Our treatment must be "wholistic" and comprehensive.

There is no such thing as purely functional disorder or purely organic disease. All organic disease produces some disorder of function and every derangement in function produces an organic change. Our crude methods of examination may not reveal such change in the latter and the functional disorder may be of minor degree in the former. Nonetheless psychosomatic medicine must take us away from the "either - or" concept in medicine. I never see disease in the "pure" form. I see only gradation of symptoms as well as gradation of pathological change. Each patient presents his own complex spectrum.

Patients have an organic substrate upon which is superimposed a "psychogenic overlay." Symptom production often depends on the relative importance of the two. I find it helpful to think of illness as an algebraic equation. For example, the tubercle bacillus is only one factor in the equation producing pulmonary tuberculosis. It was interesting to me to hear from an eminent bacteriologist who has spent a lifetime of research on the tubercle bacillus, the opinion that the tubercle bacillus is the least important factor in the equation and that others such as heredity, nutrition, sociological and emotional factors were of greater import.

With psychosomatic medicine we are therefore being helped to a better perspective to reintegrate the patient, his feelings, personality and background into the practice of medicine.

I would like with the help of a few illustrative cases to develop with you some of these ideas of psychosomatic medicine and to state the thesis that psychotherapy which is the art of medicine at its highest ethical plane is the responsibility of the family doctor and that he is the one who should do the best psychotherapy. To my mind it includes non-verbal as well as verbal patient-physician relationships. It is largely an emotional rather than an intellectual experience. As its goal there is implied a mutual growing up process. All psychotherapy is not necessarily good, as I shall presently point out. When I use the

term, I am therefore using it with the broadest connotation possible.

I will try to present the proposition that the bulk of psychotherapy must be administered by the family doctor—that he can and should be the physician best qualified.

The first two cases to be presented illustrate the difficulties psychiatrists can have in treating the sick because of their inability to give some patients comprehensive care, and demonstrate that organic changes in the brain can produce what might be called functional syndromes.

A 55 year old nun was scheduled to receive electro-shock therapy for treatment of what her psychiatrist felt was a typical involutional depression. At the request of the family, she was seen in consultation. During a routine physical examination a soft blowing aortic diastolic murmur was heard along the left sternal border. A blood sample was discreetly drawn and when a positive report of a serologic test for syphilis was obtained, lumbar puncture was performed. Her cerebro-spinal fluid revealed many lymphocytes, a high protein content and a paretic gold curve formula. Penicillin therapy produced an arrest in the progress of her disease. From the psychiatric point of view, this patient presented a picture no different from that of many other women who developed this type of depressive illness.

A 43 year old housewife was seen because of frequent atypical psychomotor and petit mal seizures which were obviously triggered by situations producing tension. The greatest problem in handling her was that she was unable to accept the fact that she was an epileptic. Electroencephalograms done almost yearly were negative. Suppressive medications did less toward reducing the frequency of her seizures than did environmental manipulation or a long interview. Once when her small son was reported injured she reacted with hysterical behavior which lasted for twelve hours and had memory loss for the entire incident. A psychiatrist at a neighboring medical center felt that her entire illness was hysterical in origin. As her family doctor I recognized over the years a changing pattern to her seizures and the relative unimportance of the emotional component and insisted that the electro-

encephalograms be repeated and an air study done. After nine years a localizing lesion turned up which at operation was a hemangioma of the temporal lobe. She is now cured of her epilepsy.

To my mind psychiatrists should still carry a stethoscope as one of the tools of their trade. An older psychiatrist once told me that he did a pelvic examination on every female patient and that he felt that this, aside from the fact that he occasionally picked up an important lesion (he was a surgeon and general practitioner by trade before he became a psychiatrist), was always an aid in establishing rapport with the patient because the examination was in intimate one. After the examination the patient would feel freer to discuss more intimate personal details in her life situation. When I mentioned this to a younger psychiatrist fresh out of training, he told me what a terrible thing this was to do from the Freudian analytic point of view, mentioning such terms as "castration complex" and "penis envy." Personally I wonder whether either point of view is correct. It is my feeling that the physician has to modify his approach with every patient. A stereotyped approach as regards any procedure is bad psychotherapy. Of course, it is good psychotherapy to examine every patient completely. The thorough physical examination constitutes one of the best non-verbal psychotherapeutic maneuvers we as family doctors have available to us. This can be destroyed in part if the patient feels that it is being carried out mechanically without regards for his feelings or his peculiar idiosyncrasies. The patient must be made to feel that the physician is really interested in him as a person and not in the methodology or in any isolated organ. I feel that the physician should be ready to modify his office ritual according to the emotional as well as the physical needs of the patient. So many doctors do this intuitively because they are good listeners and good observers. Others spend an hour in a tedium of painstaking history-taking to fill out all the lines on a blank and another hour or two looking at every square inch of epidermis and into every body orifice and still miss the obvious clues that the family doctor can pick up in two minutes. To me, nothing is

more stultifying than to approach the patient with a head-to-toe list of questions as I was taught to do in medical school and as we still employ for writing up our case material. I am reminded of the students who are trying so hard to remember which comes first, the family history, personal history, dietary history, or present illness, that they frequently forget why the patient came to the hospital in the first place. Those of you who have been in practice for many years know perfectly well that if you just let the patient talk, that most of the time they will tell you what is wrong with them. Another point that I wish to make is that no doctor should feel so pompous as to be ashamed to ask the patient what he or she thinks is the matter with them.

The next two cases illustrate how so-called organic and functional disease co-exist in the same patient and may even produce the same symptoms.

A 28 year old white male for four years had bouts of diarrhea alternating with constipation, abdominal pain and even on occasions when his symptoms were intense noted the passage of bright red blood. Repeated examinations by several physicians, including myself, were entirely normal. These examinations included x-ray studies of the gastrointestinal tract, stool examinations and sigmoidoscopy. He was studied more intensively at a neighboring medical center. Here all of his physical examinations were likewise negative. His work-up included, however, a psychiatric interview in which he was given insight into the psycho-dynamics of his symptoms. Not a great deal of improvement resulted in his symptomatology but the patient was less anxious over his condition. Two years after this detailed examination, he again had recurrent rectal bleeding and again this coincided with conflictual stress and he dismissed this to himself again as "nerves" and delayed examination until his family prevailed upon him because of his weight loss. On examination he had an annular carcinoma of the rectum which fortunately was resectable.

Although this patient had adequate reasons for his symptoms entirely on an emotional basis, an organic lesion of the bowel developed. Frequently the symptoms and the signs of dis-

ease are so camouflaged by emotional overlay that the physician is hard put to pick up and evaluate properly the earliest symptoms of carcinoma or some metabolic disorder. Where the patient's complaints have a strong neurotic flavor, the physician with a psychiatric orientation might find many explanations in the patient's emotional life, and verily the analyst can frequently construct the dynamics carefully and completely, and yet overlook an important disease state. The organically oriented physician, on the other hand, might examine and re-examine until mayhap he might find an amoeba in the stool or an innocent diverticulum. We need more doctors who are properly oriented who can appreciate and feel the patient's emotional needs as well as attend to all of his physical complaints. Only the family doctor can serve this function well.

A middle-aged school teacher with a long history of neurotic complaints developed nausea and vomiting whenever, in organ language, her life situation became more than she could stomach. Her symptoms always had an emotional coloring, for example: the school principal lived next door and if she happened to eat a meal while facing the window which overlooked his house, she would very promptly vomit. The same meal eaten in different surroundings was well tolerated. X-rays of the stomach were repeatedly negative, but in six months this patient was dead and an autopsy showed she had a schirrhous carcinoma of the stomach. Were her symptoms due to carcinoma of the stomach? Probably only a few and then only toward the end of her life. Only a keen family physician is able to evaluate this type of patient in the face of negative x-ray examinations when the patient's neurotic traits plague and confuse him.

The "old-timers" who used to rely more on their own end organ receptors rather than the reports of a laboratory or an x-ray or an electrocardiographic interpretation could do it. They could diagnose a "broken heart" as well as a "broken bone." They could mend a family crack-up as well as they could sew up Junior's cuts. They could smell typhoid fever and hear laryngeal stridor. And yet they could sit and listen for hours to everyone's troubles.

They were psychotherapists of the first order, and yet I am sure that many of them would have laughed at the idea of being called one. I dare say that for every patient helped by formal psycho-analysis, countless thousands have been helped by just such psychotherapists. They were not scientific, but as we know psychotherapy probably never will be a science. "Psychiatry" to many of them was just so much mumbo-jumbo, but many of them practiced the brand of psychotherapy which we must envy and marvel about. I am reminded of the kind of psychotherapy sometimes practiced by many of these men who were not only keen clinicians but warm, understanding, kindly and tolerant physicians by this anecdote:

Many years ago a prominent banker in my town after traveling from doctor to doctor and clinic to clinic in search of help for a disabling neurosis, consulted an eminent physician in Philadelphia. Without the benefit of psycho-analysis but with the benefit of the depth of understanding seldom surpassed, he told this patient, "I have two words of instruction and advice for you which must be followed explicitly. If you do this you will get well." The banker who by now had submitted to all conceivable forms of treatment replied, "Anything you advise, I will carry out." Whereupon the wise old doctor then said, "My advice to you, young man, is 'Walk home.'" The somewhat astounded banker did, however, follow this advice and after many weeks of walking the open road experienced some type of spiritual reawakening, acquired along the way a better philosophy of life, began to see himself in a different light, and arrived home a man no longer self-centered and cured of his neurosis. I am told that even until the time of his recent death, he required no psychiatric care.

To further illustrate the impossibility of separating organic and functional disease, I would like next to relate a headache problem.

A 47 year old housewife gave a life-long history of headaches. Careful delineation of symptomatology disclosed that there were several different types of headache present. There were classical migraine attacks which occurred monthly, ushered in with scintillating

scotomata, and violent unilateral head pain followed by nausea and vomiting. This type of headache would be relieved effectively with ergotamine or its derivatives. She also had headache which was in effect an occipital neuralgia which was dull and continuous, not accompanied by nausea, worse in the mornings immediately upon arising, but relieved by movement of the head and neck. X-rays revealed an advanced osteoarthritis of the neck. Cervical traction afforded a considerable measure of relief of this type of headache. In addition she had headache which was characteristic of the tension-type accompanied by tight neck muscles, frequently initiated by a trying experience, dull, constant and accompanied with a tight band sensation around the head. There were many and adequate reasons for tension headaches: from marital strife, the problems of an adolescent daughter, and financial worries. Sometimes her migraine would be triggered by the let-down after long continued stress, and often a food allergy would be the apparent offender. Sometimes on a cloudy day she had more arthritic and myositic pain. At other times it was just the husband who was an ordinary "pain in the neck." Now with this background four years ago this patient began to develop more frequent headaches and still different headaches, but also some pain and weakness down the left half of the body. X-rays of the skull revealed progression of what is commonly called hyperostosis frontalis interna but which in her situation was a hyperostosis fronto-parietalis. Because of increasing brain damage as evidenced by a change in gait and muscular atrophy, she was operated on three years ago and a window of bone was removed from the parietal area of the skull. At this operation, the brain surface was found to be deeply indented by this unusually thick, bony growth. Following the operation she experienced partial relief of symptoms; however, during the past year her headaches again became persistent and more severe. Because of progressive unilateral muscular weakness, she was advised to have a second operation with the idea of removing a larger bone flap. This was done several weeks ago and a meningioma was found and successfully removed.

This case illustrates the importance of proper evaluation of the relative importance of physical and psychological factors in symptom production. Even for a working diagnosis, to classify a patient's illness as being either functional or organic is implying a dangerous concept. All patients have aspects of both. In some, as for example an anxiety reaction, the predominant background may be emotional or, in the case of a fracture, this might be classified as organic. However, some patients present the clinical picture of anxiety reaction and are cured when a sub-sternal goitre is removed and some patients with fracture are found to be accident-prone individuals perhaps with a deeply concealed death wish. Could you call this patient's illness psychosomatic or somatopsychic? Which kind of specialist is best equipped to handle this type of problem? And here again the answer is apparent; only the family doctor who not only has to evaluate the relative importance of each factor in the equation of her illness, but also has to be the entrepreneur in obtaining for her neurosurgical, orthopedic, and physiotherapeutic skills which she needed in treatment. I have not mentioned psychiatrists because she jokingly told me that she needed one of those fellows about as much as she needed "a hole in the head."

The next cases illustrate the administration of poor overall psychotherapy by the psychiatrist when the patient's needs might have been better met by the family doctor.

A 28 year old housewife and mother of two was seen because of an anxiety reaction which centered around the fear of heart disease. She would awaken at night in great distress with air hunger, palpitation and fear of imminent death. Her physical examination and electrocardiographic studies were entirely normal. She was an only daughter, indulged by her parents, who were themselves preoccupied with problems of health. Hospitalization was advised for purposes of psychiatric consultation, adjunctive therapy such as sub-shock insulin and superficial psychotherapy. Being a medical shopper, however, she ended up at a large eastern teaching hospital where all physical examinations and other studies were repeated with negative findings. She was

accordingly referred to a psychiatrist with analytic training. In three interviews using the combination of straight history taking, free association techniques, and hypnosis, he unearthed three previously unconfessed premarital love affairs. She was then placed in a psychiatric institute behind bars with a diagnosis of schizophrenic reaction. After too short a period of hospitalization to permit definitive psychotherapy, the family signed a release and she was discharged. The net result was a stigmatizing diagnosis of schizophrenia, probably incorrect, a disturbed marital relationship with a disillusioned husband, a depressive reaction in the father who felt that his whole life was a failure reflected in his daughter's illness and such agitation in the mother who had for many years been a labile hypertensive that she again developed a marked elevation of blood pressure and disabling symptoms.

The discreet family doctor can often by superficial psychotherapy, including somatic methods such as sub-shock insulin, achieve more for the patient and for the family than can the psychiatrist in the big city. What appears queer or schizoid to a psychiatrist in a large metropolitan area sometimes may represent modes of thinking peculiar to the patient's family and environmental group. I recall that one of my patients saw a psychiatrist in a large mid-western city, and that he was overly impressed by many of her peculiarities. When her local psychiatrist who knew her intimately for fifteen years and knew everything about her family and her city as well heard of this, he could chuckle and make the comment, "That ain't schizophrenia, that's Charleston."

Patients have families, (and here I am borrowing the title of Richardson's book) and their psychotherapy must be directed at the family constellation as well as the patient. The family doctor is peculiarly suited to administer such therapy. The family doctor had in general better leave alone analytic methods, suggestive hypnotherapy, electro-shock therapy, and many other psychiatric methods in much the same manner as he would not attempt to do a lobectomy or a craniotomy. It is his job, however, to learn which patients are likely to be benefited by them, much in the manner that he learns which patients should consider

surgery for cancer of the lung. Recommending deep or major psychotherapy is like advising major surgery. Not all patients with lung cancer are operable. The family doctor helps evaluate which ones can be helped. It is not wise to recommend psycho-analysis for a patient unless it is certain that the patient will be able to spend the time and money involved. If this is not possible, it is better for the patient not to embark on such therapy at all. Some of the unhappiest patients I have known have been "halfanalyzed."

A 49 year old business executive had disabling anxiety attacks with chest pain and tachycardia and required at least six hospital admissions. On each occasion electrocardiographic studies revealed no evidence of myocardial infarction. In spite of psychiatric care, he remained in constant fear of a heart attack and could not bring himself to propose to a fine woman to whom he had been devoted for many years. With the help of his family doctor, he achieved understanding and support and was able to survive a genuine myocardial infarct two years later and finally to consummate a happy marriage. Oftentimes, only the family doctor, and I include the internist in this category, by virtue of his total approach to the patient's situation, is able to administer effective psychotherapy. The psychiatrist cannot be completely sure himself that the patient's chest pain is not significant, and hence cannot give complete reassurance. This is the type of patient who is apt to ask, "How do you know this attack is not my heart when you haven't even examined it?"

As I have implied, not all psychotherapy is verbal. Some psychotherapy involves physical methods, even punitive ones. Some doctors I know practice their particular brand of psychotherapy by giving shots for everything. I maintain that the family doctor can be a psychotherapist with a needle, provided he knows what he is doing. If he is giving an innocuous substance at periodic intervals to provide a definite reason for a certain type of patient to return at a particular time and if he utilizes this time for a psychotherapeutic approach, this may be legitimate. Many patients in this way are given a convenient exit for the symptoms which they could not accept by going to

a doctor who simply talked to them but didn't do anything for them. Psychotherapy is sometimes practiced with a knife and many times the doctor even convinces himself that a good result obtained is due to the scalpel.

A case in point is that of a minister in his declining years who developed a depleting, influenza-like illness. During his convalescence he sensed, but he could not accept in many ways, that retirement from his pulpit was now best for all concerned. He could not, however, stand up to the situation. As a consequence, when he went before his congregation on Sunday, he had a weak spell and had to be carried home from church. His family doctor had him admitted to the hospital for a thorough-going diagnostic overhaul to find out what the trouble was. An internist also saw him in consultation. The examinations were all negative for he was an unusually healthy man for his years, but his x-rays revealed a normally functioning gall bladder with a solitary large stone. Reassurance that no organic disease was found and that the gall stone was not producing his symptoms did not help, and he was made considerably worse when his doctor told him that he had "pulpitis."

A doctor in a neighboring small town told him that he needed a cholecystectomy and would be helped. Removal of his gall bladder did help him to feel that his ills were not psychic in origin and also gave him a convenient "exit for his symptoms." He could talk now more freely with the congregation about his troubles and even had something concrete—that is, a stone—to show them. But this is not an illustration of good psychotherapy. We have all seen the worst of this type of psychotherapy in the poor surgically addicted women who have had a uterus suspended, a cyst removed from an ovary, an appendectomy, an operation for adhesions, and finally perhaps a hysterectomy or cholecystectomy—what one doctor I heard one time call "the standard operations." I am not criticizing the surgeons here. I am merely pointing out that psychotherapy is implicit in the practice of their skills, that such psychotherapy can be legitimate and good in a majority of cases, but that the patients who get better of a neurosis following surgery do not improve necessarily be-

cause the offending organ has been removed.

Metabolic illness, either unrecognized, possibly not yet described or understood, may be responsible for psychic disturbance which would fit into the neurotic pattern. When these occur in patients whose life situations apparently explain the neurosis, diagnosis is doubly difficult. The family doctor with intimate knowledge of his patient's emotional needs is best equipped to recognize and treat these illnesses.

A young newly-wed was seen because of abdominal pain after eating a suspicious tomato salad. A tentative diagnosis of gastroenteritis was made; however, on the second day a generalized convulsive seizure occurred and unexplained hypertension developed. Because of localizing tenderness in the right lower quadrant with muscle spasm and also because of leucocytosis, an appendectomy was performed. The appendix was normal. During her post-operative course, the patient complained bitterly of backaches and pains in the legs and was generally irritable and difficult to manage. All examinations including urograms were negative. The patient was variously considered to be a spoiled and petted bride, a psychoneurotic, and a possible drug addict until the urine was found to turn dark in sunlight and to give a positive test for porphobilinogen. It was then clear that all of her complaints were due to acute porphyria. History taking revealed that her mother died of a similar illness after several needless laparotomies.

Thus far with the help of several illustrative cases, I have attempted to show that the key figure in the handling of the sick must be the well trained and well oriented family doctor.

I should like to summarize my views on his place in psychotherapy on a musical note—since psychotherapy is more an art than a science.

There are all sorts of musicians. Some are self-taught, some attend a conservatory. Some read notes; some play by ear. Some have mastered the classics after many years of study and become concert performers. Generally these musicians are not adept at improvisation, that is to say they would not be at home in a "jam session". The classics they play reach a

limited audience.

There are also popular musicians, usually not as well trained, who have inborn talent, who are adept at improvisation but who have a feeling for their music and who play with beauty and an appeal to the masses.

By analogy there are all sorts of psychotherapists. The psychoanalyst is the concert pianist who plays a Chopin concert while the family doctor plays an Irving Berlin tune on any instrument which happens to be handy.

The psychiatrist has had special training—and so to speak may "read the notes" or use a "formal approach" to psychotherapy. The family doctor largely plays his music by ear and can, for example, intuitively sense "disharmony" in a family relationship. He must be able to play many instruments even though lacking "polished technique" in any — that is to say he must be able to utilize many modelities of treatment.

Whereas the concert pianist can reach only a few, the popular musician reaches many. Both, however, can produce beautiful music. A musician with a natural gift can still be taught to appreciate the classics. It is easier still to learn how to read musical notes and play simple melodies. It is impossible, however, to teach improvisation — some inner spark seems to be needed.

Some doctors have a natural bent for psychotherapy. They know intuitively how to behave toward a patient, what and when to say at the right moment. They can implement their usefulness by a study of psychiatry. There are others, however, who are "tone deaf." How many of you know doctors who are always playing "sour notes"? Sometimes we don't make music at all—just noise.

I could carry the analogy further, but I have already talked too much and said too little.

Let me therefore summarize:

All doctors, with the possible exception of pathologists, practice psychotherapy. Some do it knowingly, some without knowledge. Some do it differently; some do it indifferently. Psychotherapy like most things, can be good, bad, or indifferent. Good psychotherapists cannot be made out of bad doctors, but many good doctors are poor psychotherapists. The family doctor possesses the natural equipment,

training, and station to do the bulk of psychotherapy. This he must recognize and adapt to the utmost of all of his natural intuitive skills. It is his responsibility to mature emotionally, to overcome the mass inferiority feelings which physicians at large have toward the emotional ills of the population.

The Incidence of Antibiotics and Sulfonamide Therapy

(A REVIEW OF 1200 CASES)

KATHLEEN RILEY, M. D.*

Charleston

A subject of professional interest is the fact that a large proportion of the population has received one of the antibiotics or sulfonamides. Although their importance as therapeutic agents is unquestioned, their sensitizing qualities and potential disease producing characteristics are significant. Therefore, it is a matter of interest to have some definite information concerning the percentage of patients exposed to an antibiotic or a sulfonamide.

A group of 1200 non-selected patients seen in a dermatologic private practice was

questioned. If the patient gave a definite history of known penicillin, aureomycin, terramycin, streptomycin, chloromycetin, or sulfonamide therapy it was recorded as positive. No attempt was made to verify the therapy. However, since most patients at the present are familiar with the names of the antibiotics and sulfonamides it can be assumed that a good history from a private patient is fairly accurate.

The following chart gives the findings obtained:

Age	Number	Penicillin	Aureo-	Terra-	Strepto-	Chloro-	Sulfonamide
1-9	153	122	63	18	4	8	68
10-19	147	98	24	10	2	4	76
20-29	281	214	43	12	5	5	106
30-39	235	171	28	12	3	6	100
40-49	202	140	34	17	4	7	89
50-59	116	76	17	2	3	5	38
60-69	40	24	5	0	0	2	12
70-79	26	19	4	1	1	1	8
TOTAL	1200	864	218	70	22	38	497

Of the antibiotics, penicillin was received most frequently by the patients. Seventy-two percent of this group received penicillin one or more times. Only a small percent of the patients gave a history of therapy with the other

four antibiotics. However, 41.4 percent of the patients stated that they had been given sulfonamides. This verifies the general opinion that approximately two thirds of the general population has been exposed to antibiotics at one time or another and more than one-third have received sulfonamides.

*Assistant Professor of Dermatology, Medical College of South Carolina.

Notes on the Treatment of Virus Infections

K. T. McKEE, M. D.*

Charleston, S. C.

Advances in the treatment of the bacterial infectious diseases by chemotherapeutic and antibiotic agents emphasize the absence of similar advances in the treatment of virus infections. With few exceptions, therapy which 15 years ago was best for virus disease is unchanged. Except for primary atypical pneumonia, which was not even discussed as such by textbooks of medicine 15 years ago, chemotherapeutic and antibiotic agents have been found effective in only four virus infections: Lymphopathia venerea, psittacosis, trachoma, and inclusion blenorrrhea. Each of these conditions is caused by a virus which is so large in the realm of disease-producing agents that it approaches bacteria in size.

A general discussion of chemotherapy of virus infections has been presented by Horsfall.¹ It is suggested in this review that since agents which most effectively control bacterial infections do so by altering the metabolism of the bacteria, the failure of the same control of viral infections is probably due to a difference in metabolic needs of viruses. Since viral multiplication is necessarily an intracellular activity, it may be that recovery from virus infection is related to alteration in the metabolism of the host cell. It is suspected that this cellular alteration may be a factor in the immunity developing in virus infections.

It has been observed that certain viruses manifest the property of interfering with multiplication of other viruses. It has also been observed that in specific instances a bacterium has been capable of interfering with development of disease due to a specific virus. This has been carried further and an isolated chemical constituent of the bacterium has proven responsible for this inhibition.¹ Such studies be-

gin to shed a little light upon the problem of the control of virus infections; however, at this time work in this field has apparently not been carried far enough to be of practical application in clinical medicine.

A brief review of some aspects of therapy of virus diseases follows. Though the various viral diseases must, of course, be managed individually, certain general principles apply more or less in the treatment of most of these disorders.

Rest of the affected parts, or of the patient, appears to be of the greatest importance. It must be emphasized in viral hepatitis and early poliomyelitis. In many of the virus diseases, the completeness of rest, both physical and emotional, cannot be overemphasized. *Nursing care*, including care of the bladder, bowels, and skin must not be overlooked. *Prevention and control of secondary infection* may make the difference between early recuperation and long morbidity, or between life and death. *Maintenance of adequate nutrition* is necessary, especially in disorders in which the disability is prolonged, or when vital organs, such as the liver, are directly involved in the infectious process. Proper control of fluid and electrolytes must not be ignored.

All of these, as stated above, are general measures, not emphasized as much in most bacterial infections, because of the prompt effects of antibiotics, but of extreme importance in the virus group of diseases in the absence of specific therapy. In addition to these general measures, in disease due to specific viruses certain special measures, or medications, have been found especially valuable.

Lymphopathia venerea, which is unfortunately uncommonly recognized in the early stages, is controlled to some extent by sulfonamides. These agents are more effective in the earlier stages of the infection.² Aureomycin and terramycin have also been reported

* Assistant Professor of Medicine.

From The Department of Medicine, Medical College of S. C., Charleston, S. C.

as being very helpful early in the disease.^{3,4} None is a specific cure of the infection, and because of tardiness of diagnosis in many instances, nothing will completely reverse the granulomatous scarring that occurs, especially in formation of rectal strictures, and surgical management is often necessary.

Though the viruses of lymphopathia and psittacosis are classed in the same group, their reaction to drugs is quite different. The sulfonamides have been found valueless in psittacosis⁵ but penicillin which has not been helpful in lymphopathia apparently is beneficial in the treatment of psittacosis.⁶ More recently aureomycin and terramycin have appeared to be even more effective. Streptomycin is of questionable value, and chloramphenicol is less effective than aureomycin.⁷ While this disease is not common, it should be recognized as a potential public health hazard, and the public should be aware of the possible danger of contact with infected birds. Unless it is thought of it is unlikely to be diagnosed because of the similarity of the picture to that of primary atypical pneumonia.⁸

In trachoma, sulfa drugs, aureomycin, terramycin, chloramphenicol are effective systemically and locally. In inclusion conjunctivitis topical sulfonamides are excellent for infants—oral dosage is advised for adults.⁹

In primary atypical pneumonia supportive and symptomatic therapy used for the treatment of bacterial pneumonias must be used. Penicillin and sulfonamides have not proven helpful. Numerous writings have discussed the value of aureomycin in the more troublesome cases and it is apparently generally believed that it shortens the course of the illness.¹⁰ However, one recent controlled study of a series of cases failed to show that any benefit occurred with the use of aureomycin.¹¹

The common cold remains a problem without any effective prophylactic or therapeutic regimen. Symptomatic therapy which is of importance to patients does not appear to affect the course of the disease. Antihistamines at first thought useful have failed in controlled studies both in prophylaxis and in treatment.¹² Antibiotics have no favorable effect in the uncomplicated case but may be useful in therapy of complications.¹³ Vaccines have

never proved of value in reducing susceptibility. Ultraviolet light has not been found to be effective in controlling the spread of respiratory infection.¹⁴

The treatment of influenza remains symptomatic and supportive. Sulfonamides and various antibiotics are frequently used in this disorder, but it should be understood that their value is not in controlling the disease, but in preventing complications secondary to bacterial infections. Complications from influenza in otherwise healthy persons, however, are not common and the wisdom of the use of such medications routinely is very doubtful. Immune serum is of no value. Influenza virus vaccine is of no value in treatment of patients with the disease.¹⁵

Protective immunization with vaccines containing influenza A and B virus has been shown to be of value for preventing or ameliorating disease due to infection with these viruses. Infection with the more recently discovered influenza A virus, however, does not appear to be prevented by A and B vaccine. After giving influenza vaccine, some degree of protection occurs within a week and gradually increases, lasting for one or more months up to about one year, probably, in some cases. In situations in which groups of people in close contact are exposed to the disorder, prophylactic vaccination may be worthwhile. It would appear, however, that immunization of the general population is unwise and impractical. It should not be forgotten that influenza vaccine, made from egg yolk cultures, may be dangerous for individuals sensitive to egg.¹⁵

Much has been written regarding the management of poliomyelitis. Once the disease has developed in an individual, no specific therapy is useful, and general principles of treatment of virus diseases should be followed in caring for these cases. Treatment needs depend entirely upon the degree of involvement by the particular process, and may vary from simple bed rest to the use of respirators or other auxiliary breathing aids. Only a few points need be emphasized here. When poliomyelitis is present in an area, those with acute respiratory or gastro-intestinal upsets should rest longer than is ordinarily thought necessary. Abortive cases should be kept at bed rest for

seven to ten days, or more. Suspected poliomyelitis cases should not be unnecessarily moved or handled. Bed rest at home is very satisfactory in most instances and should be resorted to instead of hospitalizing all cases, many of which may be made worse by such unnecessary travel. There is said to be little danger of home managed cases endangering other members of the family, if reasonable precaution is taken, especially if gamma globulin is given to the other members.^{16 17} Details of the management of paralytic and bulbar cases can be found in many articles and textbooks.

Priscoline has been recommended as an effective agent in producing vaso-dilatation and thereby reducing painful muscle spasm of the extremities and peripheral vascular spasm in poliomyelitis. The interesting possibility that sudden respiratory failure in some cases may be due to pulmonary angiospasm and that here too priscoline is worthwhile has been presented recently.¹⁸

The use of gamma globulin in the prophylaxis of poliomyelitis has been discussed by a number of writers. This substance, containing antibody against all of the three known types of poliomyelitis virus, has been used in doses of 0.14 c. c. per pound of body weight in numerous field studies of local polio epidemics. Hammon's conclusions based upon three field tests are that the disease is not prevented in patients who received gamma globulin one week before the onset of first symptoms, but was modified in seventy; for the period between two and five weeks after injection of gamma globulin the occurrence of poliomyelitis was much less in persons given gamma globulin than in those given control gelatin; after the fifth week protection waned and no significant protection remained after the eighth week.¹⁹ That all authorities are not completely in agreement with these conclusions is apparent from Sabin's comment.²⁰

The availability of protective vaccination against poliomyelitis in the near future appears probable, though it is doubtful that vaccines for general use will be produced by the coming season.²¹

Viral hepatitis, which has become of great importance to us in the past ten years, has been recognized as consisting of two separate

entities; infectious (epidemic) hepatitis, and serum hepatitis. Most authorities agree that they are caused by two different viruses. Infectious hepatitis, viral hepatitis A, with an incubation period of 10-40 days is transmitted by the intestinal-oral route, while serum hepatitis, viral hepatitis B, with an incubation period averaging 60-150 days, is transmitted by contaminated plasma, needles, syringes, blood, etc. Decision as to which form the patient has may be of importance epidemiologically. It has been observed that gamma globulin is effective in prophylaxis of infectious hepatitis, if given in the incubation period of the disease and is effective as late as 6 days before onset of the disease. As small a quantity as 0.01 c. c. per pound of body weight may be a sufficient dose.²² Its use especially should be considered in families in which the disease has appeared.²³ Gamma globulin has not appeared to be of value in preventing serum hepatitis.²⁴

In general, antibiotics are not indicated in treatment of viral hepatitis. Aureomycin has been reported of some value in very ill patients or patients in hepatic coma. ACTH also has been tried; the results reported as to some shortening of the disease were not very striking, and it is generally felt that its questionable value does not justify the expense and dangers associated with its use in this disorder.²⁵ Treatment in general is supportive. Bed rest is most important. The duration of rest needed is not known exactly, however, it certainly seems best to keep patients in bed until jaundice has disappeared and bromsulphalein excretion has returned to normal. A diet high in carbohydrates (350-400 grams) and in protein (150-200 grams) is needed. The amount of fat under these circumstances is apparently unimportant. Vitamins may be added. Choline, methionine, and the other lipotropic agents apparently are of no value in viral hepatitis.²⁵

In chronic hepatitis, bed rest, a good diet, and vitamins again appear to be the most important items.

For control of hepatitis proper sanitation, fly control, and elimination of infected food handlers should be kept in mind. Stools of cases of infectious hepatitis should be con-

sidered potentially infectious for at least a month after onset of the disease. Patients should never act as blood donors. Plasma should not be used. All needles and syringes should be autoclaved before use.²⁶

In infectious mononucleosis the question of the efficacy of antibiotics especially aureomycin and chloramphenicol has come up repeatedly and varying opinions as to their effectiveness exist. In the absence of more definite proof to the contrary it is probably safe to assume that no specific therapy exists.²⁷ The general measures necessary for treatment vary widely because of the diversity of clinical pictures which may be manifest by the disorder.

For rabies there is no specific therapeutic agent. It has been recommended that barbiturates be used rather than morphine for control of the anxiety of cases and that general anesthesia be used for convulsive seizures.²⁸

Generally accepted indications for the use of rabies vaccine for persons bitten or scratched include situations 1) when the animal is apprehended and has clinical signs of rabies, 2) when the brain of the killed animal is positive for rabies by microscopic examination, 3) when the animal is killed, and even though the brain is negative was suspected of having rabies; 4) when an individual is injured by a stray animal that has escaped or cannot be identified.²⁸

Encouraging reports on the use of hyper-immune serum in prophylaxis of rabies have appeared.²⁹ This material in all probability will be a useful addition to the prophylaxis of rabies, though it has not yet been used sufficiently to have an established place in the prophylactic routine.

Much has been written on the dangers of rabies vaccine and the complications arising from its use.³⁰ The development of less toxic vaccines and more final proof of the value of passive immunization will be awaited with interest.

The effectiveness of gamma globulin for the prophylaxis of measles is well known. One-tenth c. c. per pound of body weight given within five days of exposure prevents the disease; 0.02 c. c. per pound in the same interval

modifies the severity of the disease but still allows for development of adequate immunity. Larger doses given later in the incubation period also modify the disease.³¹ Antibiotics are very useful in control of bacterial infections which occur as complications of measles. Gamma globulin (1 c. c. per pound) given intra-muscularly over a 36-48 hour period in measles encephalitis has been recommended recently.³⁰ At present it appears unlikely that such therapy is practical to apply due to the shortage of gamma globulin for general use.

The prophylaxis of mumps at this time, by various preparations of dead or attenuated mumps virus is apparently of uncertain value.³³ Immune serum or gamma globulin in treatment of orchitis or meningitis has been recommended but their value is not yet established. Diethylstilbestrol for orchitis is also of questionable benefit.³⁴

Herpes simplex infections at times present a problem, since in addition to the simple herpetic lesion or "cold sore" about the mouth, generalized herpetic eczema, herpetic stomatitis, and herpetic meningitis occur. No specific therapeutic measures are available. The use of antibiotics to control secondary infection may be necessary. Numerous local applications have been tried; none seems remarkably good. Repeated small pox vaccination has been recommended.

Herpes zoster, the virus of which is closely related to, if not identical with, the virus of chicken pox also often presents a problem in treatment. Local cleanliness, antibiotics for secondary infection and sedative ointments seem the best therapy. Aureomycin was at one time thought a specific remedy—further observations have not substantiated earlier impressions.³⁵ Among other things, deep x-ray therapy and even section of sensory nerve roots have been recommended for the remaining severe post-herpetic neuralgia which is not rare in older patients with the disease.³⁶

Several recently described virus infections have been the subject of a number of articles. In none of them has any specific therapeutic routine been recommended as useful. These include cat scratch disease, epidemic hemorrhagic fever, herpangina (a coxsacki virus infection). The same is true of the older well-

known disease entity, Bornholm disease or epidemic pleurodynia, which has only in recent years been shown to be caused by the coxsackie virus. One writer has reported a favorable response in pleurodynia to treatment with aureomycin.³⁷

It is apparent that the therapy of virus diseases is in most instances unchanged from that of past years. In some infections prophylactic injection of gamma globulin has proven of definite worth, and should be used when the indications are adequate. Antibiotics have no place in the treatment of most uncomplicated virus infections; at times their usage is justified by the danger of development of secondary infection.

BIBLIOGRAPHY

1. Horstfall, F. L., Jr.: Chemotherapy in Viral Infections. *Am. J. M. Sc.* 220:91, 1950.
2. Meyers, K. F.: Psittacosis-Lymphogranuloma Group. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 458; 1952.
3. Wright, L. T., Sanders, M., Logan, M. A., Prigot, A., Hill, L. M.: The Treatment of Lymphogranuloma Venereum and Granuloma Inguinale in Humans With Aureomycin. *Ann. New York Acad. Sc.* 51:318; 1948.
4. Hurst, E. W., Peters, J. M., Melvin, P.: The Therapy of Experimental Psittacosis and Lymphogranuloma Venereum (Inguinale). I The Comparative Efficacy of Penicillin, Chloramphenicol, Aureomycin, and Terramycin. *Brit. J. Pharmacol.* 5:611; 1950.
5. Levinson, D. C., Gibbs, J., Beardwood, J. T., Jr.: Ornithosis as a Cause of Sporadic Atypical Pneumonia. *J. A. M. A.* 126:1079; 1944.
6. Woline, W.: Ornithosis (Psittacosis). A Review With Report of Eight Cases Resulting From Contact With the Domestic Pekin Duck. *Am. J. M. Sc.* 216:551; 1948.
7. Kneeland, Y., Jr., Price, K. M.: Treatment With Chloramphenicol, Aureomycin, and Terramycin of the Pneumonia of Mice Caused by Feline Pneumonitis Virus. *J. Immunol.* 65:653; 1950.
8. MacLachlan, R. W. G., Crum, G. E., Kleinschmidt, R. F., Wehrle, P. F.: *Am. J. M. Sc.* 226:157; 1953.
9. Thygeson, P.: Trachoma and Inclusion Conjunctivitis. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 465; 1952.
10. Finland, M.: Antimicrobial Treatment of Virus and Related Infections. *New England J. Med.* 247:317; 1952.
11. Walker, S. H.: Ineffectiveness of Aureomycin in Primary Atypical Pneumonia. A Controlled study of 212 Cases. *Am. J. Med.* 15:593; 1953.
12. Feller, A. E., Badger, G. F., Hodges, R. G., Jordan, W. S., Jr., Rammelcamp, C. H., Jr., Dingle, J. H.: The Failure of Antihistaminic Drugs to Prevent or Cure the Common Cold and Undifferentiated Respiratory Diseases. *New England J. Med.* 242:737; 1950.
13. Finland, M.: Antimicrobial Treatment of Virus and Related Infections. *New England J. Med.* 247:557; 1952.
14. Reimann, H. A.: Progress in Internal Medicine—Infectious Diseases. *A. M. A. Arch. Int. Med.* 91:353; 1953.
15. Horsfall, F. L., Jr.: Influenza. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 392; 1952.
16. Stimson, P. M.: Home Care of Patients With Acute Poliomyelitis. *J. A. M. A.* 149:719; 1952.
17. Batson, Randolph: Medical Management of the Polio Problem. *Ann. Pract. & Digest of Treat.* 4:305; 1953.
18. Smith, E., Harris, I. L., Rosenblatt, P.: Acute Poliomyelitis. A Clinical and Statistical Study of 263 Cases. *J. Pediat.* 43:9; 1953.
19. Hammon, W. McD., Coriell, L. L., Wehrle, P. F., Stokes, J., Jr.: Evaluation of Red Cross Gamma Globulin as a Prophylactic Agent in Poliomyelitis. IV Final Report of Results Based on Clinical Diagnosis. *J. A. M. A.* 151:1272; 1953.
20. Sabin, A. B.: Gamma Globulin in the Prophylaxis of Poliomyelitis: A Critical Analysis of Available Data. *Ohio M. J.* 49:603; 1953.
21. Salk, J. E., Bennett, B. L., Lewis, L. J., Ward, E. N., Youngner, J. S.: Studies in Human Subjects on Active Immunization Against Poliomyelitis. I. A Preliminary Report of Experiments in Progress. *J. A. M. A.* 151:1081; 1953.
22. Stokes, J., Jr., Farquhar, J. A., Drake, M. E., Capps, R. B., Ward, C. S., Jr., Kitts, A. W.: Infectious Hepatitis: Duration of Protection by Gamma Globulin. *J. A. M. A.* 147:714; 1951.
23. Brooks, B. F., Hsia, D. Yi-Yung, Gellis, S. S.: Family Outbreak of Infectious Hepatitis. Prophylactic Use of Gamma Globulin. *New England J. Med.* 249:58; 1953.
24. Stokes, J., Jr.: Viral Hepatitis. *Am. J. M. Sc.* 225:349; 1953.
25. Gellis, S. S., Hsia, D. Yi-Yung: Viral Hepatitis. *New England J. Med.* 249:400; 1953.
26. Havens, W. P., Jr., Paul, J. R.: Infectious Hepatitis and Serum Hepatitis. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 359; 1952.
27. Walker, S. H.: The Failure of Antibiotic Therapy in Infectious Mononucleosis. *Am. J. M. Sc.* 226:65; 1953.
28. Johnson, H. N.: Rabies. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 267; 1952.
29. Koprowski, H., Cox, H. R.: Recent Developments in The Prophylaxis of Rabies. *Am. J. Pub. Health.* 41:1483; 1951.
30. Editorial: Prevention of Rabies. *J. A. M. A.* 149:1318; 1952.
31. Bivings, L.: Gamma Globulin Dosage and Measles Control. *J. Pediat.* 43:401; 1953.
32. Odessky, L., Bedo, A. V., Jennings, K. G., Sands, I. J., Rosenblatt, P., Weisler, H., Newman, B.: Therapeutic Doses of Gamma Globulin in the Treatment of Measles Encephalitis and Encephalomyelitis; I. A Clinical Study of Forty-One Cases with Follow-Up Studies. *J. Pediat.* 43:536; 1953.
33. Bashc, W. J., Jr., Gotlieb, T., Henle, G., Henle, W.: Studies in the Prevention of Mumps. VI. The Relationship of Neutralizing Antibodies to the Determination of Susceptibility and to the Evaluation of Immunization Procedures. *J. Immunol.* 71:76; 1953.
34. Hayne, A. L., Diamond, J. H., Christian, J. R.: Diethylstilbesterol in Mumps Orchitis. *J. A. M. A.* 140:662; 1949.
35. Kass, E. H., Aycock, R. R., Finland, M.: Clinical Evaluation of Aureomycin and Chloramphenicol in Herpes Zoster. *New England J. Med.* 246:167; 1952.
36. Stokes, J., Jr.: Varicella-Herpes Zoster Group. In *Viral and Rickettsial Infections of Man*. 2nd Ed., J. B. Lippincott Co. p. 506; 1952.
37. Nichamin, S. J.: Pleurodynia in Children. Clinical Observations in Fifty-Four Cases. *J. A. M. A.* 148:1002; 1952.

The Management of Hemorrhage in the Last Half of Pregnancy^{*}

JOHN R. McCAIN, M. D.

Hemorrhage has become relatively more prominent in recent years as a cause of maternal mortality in the United States. Maternal deaths from infection and from toxemia have decreased more rapidly than have the deaths from hemorrhage. Nearly 1000 women died from hemorrhage associated with pregnancy in 1950. In addition to the maternal deaths, at least 10,000 infants died because of the conditions associated with hemorrhage in the last half of pregnancy.

Major hemorrhages in the last half of pregnancy are usually caused by placenta previa, abruptio placenta, or by a rupture of the marginal sinus of the placenta. At least as many women have bleeding in the last half of pregnancy from other conditions as have bleeding from the causes of major hemorrhage. Slight amounts of bleeding in the last half of pregnancy are not unusual and may come from premature labor, cervical lesions, or even from a trichomonas vaginitis. Bleeding in the last four and a half months of pregnancy cannot be ignored simply because the amount of blood loss is not excessive. A small amount of bleeding may be the first warning of a serious cause for hemorrhage. Every physician in charge of an obstetrical patient must be aware of the dangers of bleeding in pregnancy. An error in the management of a patient with hemorrhage may terminate abruptly in shock and death. The purpose of this discussion is to review the methods of recognizing and treating the causes of major hemorrhage in the last half of pregnancy.

Placenta Previa

A placenta which completely covers, partially covers, or approaches the internal os of the cervix is called a placenta previa. The placenta covering the entire internal os is called a complete placenta previa. If the pla-

centa covers only a part of the internal os it is called a partial placenta previa. If the lowest margin of the placenta reaches, or approaches, the internal os it is called a low implantation of the placenta.

The incidence of placenta previa is usually reported at about 0.5%. This is approximately the frequency with which we have encountered a placenta previa at Grady Memorial Hospital. Patients with a high parity have a considerably higher incidence of placenta previa. Women who have had over five deliveries are found to have a placenta previa in 5% of their deliveries.¹

The maternal mortality rate is relatively low, usually being reported at less than 1%. At Grady Memorial Hospital in the past five years we have delivered approximately 125 patients with placenta previa. One patient with placenta previa died. The cause of her death was a pulmonary edema produced by an excessive amount of blood administered too rapidly in the replacement of her blood loss.

The infant mortality rate in patients with placenta previa is approximately 25%. The prematurity of the infant at delivery contributes heavily to the high death rate. At the first episode of bleeding, over half of the infants are premature.²

Diagnosis: The character and the time of the bleeding are of considerable value in recognizing that the cause is a placenta previa. The bleeding is classically and accurately described as being painless and causeless. The onset of the hemorrhage is sudden, without any prodromal symptoms and without any discomfort. The blood is bright red in color, in contrast to the dark color of the blood usually seen with an abruptio of the placenta. Shock is not unusual in patients with a hemorrhage from placenta previa, but the severity of the shock is proportionate to the amount of the blood loss. The stage of gestation at which the first hemorrhage takes place is important. The

^{*} From the Department of Obstetrics and Gynecology of Emory University School of Medicine and Grady Memorial Hospital.

earlier the hemorrhage occurs in the pregnancy, the greater is the probability that the placenta previa is of the central type. Repeated episodes of hemorrhage during the pregnancy increase the likelihood that a partial or complete placenta previa is present rather than a low implantation of the placenta.

Röntgenographic studies can be of considerable value in determining the position of the placenta within the uterus. Soft tissue techniques alone, or combined with the injection of radio-opaque fluids into the bladder, may be used. By these methods it should be possible to localize the placenta in over fifty per cent of the patients.³ The position of the fetus, as determined radiologically or clinically, may also be of value. A transverse lie, a breech presentation, or other mal-position of the fetus suggest that a placenta previa may be present.

The definite diagnosis of a placenta previa as the cause of the bleeding cannot be made before delivery except by a vaginal examination. At the vaginal examination the physician must insert the examining finger through the cervical canal and palpate the placenta at, or over, the internal os of the cervix. The placental tissue can be recognized by its characteristic "gritty" sensation, as described by Eastman.² The gritty sensation of placental tissue differentiates it from the smooth resilient sensation of a partially organized blood clot which is sometimes found at the internal os in patients who have bled from conditions other than a placenta previa. Since one-third or less of the hemorrhages in the last half of pregnancy are caused by a placenta previa,⁴ a positive diagnosis of a placenta previa should be made by a vaginal palpation in every case before a cesarean section is undertaken for the delivery of the patient. The women who have had significant amounts of hemorrhage should be examined vaginally in the operating room with preparations already completed for a cesarean section to be performed immediately if a placenta previa is found which requires a cesarean.

If the physician plans to use the so-called "expectant plan of treatment" to carry the pregnancy nearer to term, the pelvic examination described above should be delayed. However, the cervix should be inspected with a

speculum to eliminate pathology of the cervix as the cause of the bleeding. In these women a definite diagnosis of the cause of the bleeding is delayed so that the infant may be given a better chance for survival.

A rectal examination, no matter how gentle, should never be made upon patients in whom the diagnosis of a placenta previa is being considered. Sudden, disastrous hemorrhage may follow even the most gentle rectal examination if a placenta previa is present.

Treatment: Patients who are suspected of having a placenta previa must be treated in a hospital. Facilities must be available for a cesarean section if it should become necessary. Blood should be cross-matched for a transfusion at the time of admission and an additional supply of blood should be held on reserve for a possible emergency. The two definitive methods of treatment for patients with a placenta previa are delivery by the vaginal route or delivery by a cesarean section. The "expectant plan of treatment" may be used if the infant is premature to postpone the final termination of the pregnancy.

The procedures which can be used at a vaginal delivery to control the bleeding consist of: (1) the rupture of the amniotic membrane, (2) the use of a Willett's scalp traction forcep, (3) a Braxton-Hicks version, and (4) the insertion of an intraovular Voorhees bag. The rupture of the amniotic membrane permits the presenting part of the infant to compress the placenta at the bleeding site. Additional compression of the bleeding site can be obtained by the use of a one pound weight as traction on a Willett's forcep which has been clamped to the scalp of the infant. This procedure can be used for a patient in whom the delivery of a living baby is anticipated. The use of versions and of Voorhees bags has greatly decreased since the safety of cesarean sections has improved. These procedures are now the treatments of choice for only an occasional patient.

A vaginal delivery tends to increase the risk to the mother because the blood loss may be profuse both before and after the delivery. The tone of the few muscle fibers in the lower uterine segment and cervix is almost completely lost by dilatation and effacement. The

contraction and retraction after delivery of the atonic musculature of the lower uterine segment is often too ineffective to physiologically ligate the uterine sinuses. Severe postpartum bleeding may result. The hemorrhage may be increased by tears of the very friable lower uterine segment and cervix at the delivery. Since a postpartum hemorrhage is frequent, a uterine pack should be inserted after every vaginal delivery of a patient with a placenta previa. The body of the uterus, the lower uterine segment, and the vagina should be packed tightly. The pack should be removed after twenty-four hours.

A vaginal delivery also increases the risk to the infant. An increasingly large area of the placenta is compressed as the infant descends through the birth canal. The increasing compression of the placenta may impair the placental circulation to the point that the infant succumbs. It is also impossible to determine before delivery the location at which the umbilical cord joins the placenta. If the cord should become compressed during the delivery, the death of the infant would be prompt.

A cesarean section is the method of choice for the delivery of many patients with placenta previa. An aseptic vaginal examination to rule out other conditions as the cause of the bleeding should be made on all of these patients before a cesarean section is begun. If a complete placenta previa is found, the preferred method of delivery is by a cesarean section. If a partial placenta previa or a low implantation of the placenta is found, the decision must be made regarding the safety of a cesarean section for the mother and for the infant as compared with the safety of a vaginal delivery. The cesarean method for delivery is favored by such conditions as primiparity, repeated episodes of profuse hemorrhage, a nearly complete placenta previa, a long undilated and ineffaced cervix with the presenting part of the infant high in the maternal pelvis, and a viable infant in good condition. On the other hand, if the presenting part of the infant is deeply engaged in the pelvis with the patient in active labor and with no evidence of fetal distress, the infant can probably be delivered safely by the vaginal route.

An expectant plan of treatment has been advocated for patients with a placenta previa if the infant is premature.^{4,5} The rationale for the expectant treatment is that the first episode of bleeding is almost never fatal unless some type of intervention is undertaken. If possible, an attempt is made to delay the termination of the pregnancy until within four weeks of the estimated date of confinement or until the infant weighs at least 2000 grams. If delivery is delayed until the infant is mature or nearly mature, the infant mortality for placenta previa should be reduced to about 10%. The expectant plan of treatment should not be undertaken if the pregnancy is within four weeks of term or if the infant weighs at least 2000 grams. The danger of prematurity in an infant this near the expected date for delivery is not great enough to justify a delay in diagnosing and treating the cause of the hemorrhage.

During the expectant treatment the patient should be under hospital supervision. The blood lost by hemorrhage must be replaced and additional blood must be kept immediately available. No rectal examination is to be made. The vaginal examination is limited to the use of a speculum to visualize the cervix and to rule out lesions of the cervix as the cause of the bleeding. If no additional bleeding occurs, the expectant treatment is continued until the spontaneous onset of labor. If bleeding occurs after the thirty-sixth week of gestation or after the baby weighs at least 2000 grams, the expectant plan of treatment is discontinued, a positive diagnosis as to the cause of the bleeding is made by palpation through the cervical canal, and definitive treatment is undertaken if placenta previa is found. (In at least half of the cases no placenta previa will be found. These patients should be sedated after the examination and later discharged from the hospital to await the spontaneous onset of labor.) If other episodes of hemorrhage develop before the thirty-sixth week of gestation, the expectant form of therapy with blood replacement may be continued unless the amount of the blood loss becomes alarming. Usually the patient will desire a definite diagnosis and treatment after experiencing two or three major hemorrhages. The diagnosis is then made by an aseptic

vaginal examination and palpation through the cervical canal. Adequate blood should be available for transfusions, and the examination should be made in an operating room. The operating room should be set up for an immediate cesarean section to be done if it is found to be indicated.

Abruptio Placenta

The abruptio placenta separates partially or completely from the site of implantation before the delivery of the infant. The condition is also called the premature separation of the normally implanted placenta, or an ablatio placenta. The positive diagnosis is made after delivery by the examination of the maternal surface of the placenta. An area of depression or compression on this surface by an adherent blood clot indicates that the placenta had separated prematurely at this site before the delivery.

The cause of an abruptio placenta is not known in most cases. A toxemia of pregnancy is found in patients with an abruptio placenta in about 50% of the cases, but its exact relationship to the abruptio is unknown. A ruptured marginal sinus is associated with a few cases of abruptio. External trauma before the onset of labor, or intrauterine trauma during operative deliveries account for a few cases of abruptio.

The incidence of abruptio placenta is usually reported to be about 0.75%. If mild cases without clinical symptoms are included the incidence is much higher. At Grady Memorial Hospital the incidence is approximately the same as that usually reported. Between 1928 and 1948 on our service, 293 cases of abruptio placenta were diagnosed in 47,066 deliveries. In the five years since 1948 an additional 27,760 deliveries have occurred on our service. If the same incidence is used which was found in the earlier report, approximately 170 cases of abruptio placenta have occurred in the past five years.

The abruptio placenta is the most dangerous cause of hemorrhage in the last half of pregnancy. The maternal mortality rate is approximately 4%. The uncorrected maternal mortality rate among the 293 cases of abruptio placenta at Grady Memorial Hospital, as reported in 1949,⁶ was 4.8%. Three maternal deaths

have occurred at Grady Memorial Hospital in the past five years (through September 1953) among the 170 cases of abruptio placenta, giving an uncorrected maternal mortality rate for these years of 1.76%. One of the three maternal deaths occurred within twenty-eight minutes after the patient was admitted to the hospital. The second patient was not recognized as having an abruptio when she first came to the hospital with her complaints and she was not admitted. She returned forty hours later with profound anemia, shock and anuria. The third patient did not develop hemorrhage or shock at the time of her delivery. She had anuria for three days after delivery and died twenty-six days postpartum of renal failure.

The infant mortality rate of patients with an abruptio placenta is about 50%. However, if the infant is alive at the time of the patient's admission to the hospital, 75% can be delivered alive.⁶

Diagnosis: The classical description of an abruptio placenta is bleeding in the last half of pregnancy associated with painful, tetanic contractions of the uterus and fetal death. The presumptive diagnosis of an abruptio placenta can be made in the last half of pregnancy if the patient presents two of these three conditions: (1) uterine hemorrhage, (2) a tetanic contraction of the uterus, or (3) fetal distress. The diagnosis can usually be made with ease, but it is occasionally difficult to make because of the variations in the clinical picture. In the past twenty-five years at Grady Memorial Hospital 17 patients with an abruptio placenta have died. In at least 3 of these an atypical clinical picture occurred and the abruptio was not recognized until the patient was in extremis or until it was revealed at autopsy. The difficulties in diagnosing an abruptio placenta are associated with the recognition of hypotensive blood pressure readings, the development of shock, the possibility of the hemorrhage being concealed and the absence of a typical tetanic contraction of the uterus.

The blood pressure level cannot be used as an accurate indication of shock. Hypertensive patients in whom an abruptio placenta develops may be admitted with a blood pressure well within so-called "normal" limits. For the given patient, however, the pressure may be

a serious hypotension and at shock levels.

The shock in patients with an abruptio placenta may be out of proportion to the amount of blood lost. This is in contradistinction to the patients with placenta previa in whom the shock is proportionate to the severity of the hemorrhage. The mechanism of the shock in a patient with an abruptio is not fully understood. A part of the shock may be accounted for by the hemorrhage occurring in patients with a toxemia of pregnancy, as is often the case. The hemorrhage of an abruptio placenta may be completely, or almost completely, concealed and little or no external bleeding may be seen. The blood can be retained within the uterine cavity and may cause a complete detachment of the placenta at its site of implantation. The amount of the concealed blood may become so great that an enlargement in the size of the uterus may be observed clinically. All patients with an abruptio should be followed closely since the blood pressure readings and the amount of hemorrhage are not reliable as indications of shock. A circulatory collapse, irreversible shock and death may develop suddenly. All possible precautions should be taken to prevent such a disaster.

A tetanic contraction of the uterus is not present in about twenty-five per cent of the patients with an abruptio. In some of the women a hypertonicity instead of a true tetany of the uterus may be observed, but in others the tone of the musculature of the uterus may appear to be normal.

Treatment: The dangers of shock and of death are imminent in patients with an abruptio placenta. Preparations should be made to be ready to transfuse the patients before, during, and after delivery if it becomes necessary. After the shock and blood loss of the abruptio have been treated, preparations should be made for the delivery of the infant. The delivery may be accomplished (1) by a cesarean section, or (2) by a vaginal delivery after the amniotic membrane has been ruptured artificially to induce or to stimulate labor.

Cesarean sections for abruptio of the placenta have not been shown to give a greater infant salvage. The only maternal indication for a cesarean section is the prevention of ex-

cessive hemorrhage. Such hemorrhage can be encountered if a true Couvelaire uterus is present in which a hemorrhagic infiltration of the myometrium is so extensive that the uterus cannot contract and retract sufficiently to prevent bleeding. A hemorrhagic infiltration of this type has not been seen on our service in the last 35 years. Although such hemorrhagic infiltrations do occur, their rarity makes them relatively unimportant clinically. If the uterus is seen at a cesarean section, its appearance may cause alarm. However, from the patients on our service it can be seen that persistent postpartum hemorrhage from a Couvelaire uterus almost never occurs. Of the 17 maternal deaths at Grady Memorial Hospital only one was associated with a postpartum hemorrhage and autopsy examination did not reveal a Couvelaire uterus. In view of this experience, an indication for a cesarean section for an abruptio placenta will be quite rare.

Patients with an abruptio of the placenta are delivered vaginally at Grady Memorial Hospital. After shock has been corrected and after the patient's condition has been stabilized, the amniotic membrane is ruptured artificially. Pituitary extract may be used to induce labor after the rupture of the membranes, provided that the usual precautions for the administration of pituitary extract are observed. The latent period between the rupture of the membranes and the onset of labor is usually short. Although the patient may be several weeks from the expected date of confinement with a cervix ordinarily classified as unfavorable, she can be expected to have a relatively short latent period before the onset of labor if an abruptio is present. Eighty-five per cent of the patients admitted with an abruptio and not in labor and with an unfavorable cervix can be expected to deliver within 18 hours after the membranes are ruptured.⁶ The prognosis for the infant in patients with an abruptio is relatively good if the infant is delivered vaginally. If the fetus is alive at the time of admission to the hospital 75% can be expected to be delivered alive.⁶

Ruptured Marginal Sinus of the Placenta

The marginal sinus of the placenta may rupture and give rise to bleeding in the last half of pregnancy. At Grady Memorial Hos-

pital the incidence of the rupture of the marginal sinus is approximately 1%, or twice as frequent as the incidence of placenta previa. The reasons for the rupture of the marginal sinus are not known. The placenta is implanted at its normal position within the uterus. It cannot be felt by the examining finger through the internal os of the cervix and it does not interfere with the delivery of the infant. The amount of the hemorrhage is not increased by the onset of labor nor by the dilatation and effacement of the cervix. The blood lost is of maternal origin and does not jeopardize the infant unless the hemorrhage produces maternal shock. For these reasons the prognosis is good for both the mother and for the infant.

Diagnosis: The actual diagnosis of the rupture of the marginal sinus as the cause of bleeding during pregnancy cannot be proven until the placenta is examined after delivery. A similarity exists between the character of the bleeding in a placenta previa with that of a ruptured marginal sinus. The amount of blood lost at a rupture of the marginal sinus is usually less than that of a major hemorrhage from a placenta previa. Repeated hemorrhages during pregnancy are not likely from a ruptured marginal sinus. However, these characteristics are not sufficient to differentiate the bleeding of a ruptured marginal sinus from the painless, causeless bleeding of a placenta previa.

Treatment: The signs and symptoms of the bleeding from a ruptured marginal sinus resemble those of a placenta previa so closely that patients with both conditions must be included for the "expectant plan of treatment" if this therapy is being used for placenta previa. This indicates that less than half of the patients treated expectantly for placenta previa will finally prove to have a fore-lying placenta. Specific treatment for a rupture of the marginal sinus is rarely indicated. In a few patients the blood loss may become so great that a blood transfusion is required.

SUMMARY

The most serious causes of hemorrhage in the last half of pregnancy are placenta previa and abruption of the placenta.

Placenta previa is associated with painless, causeless bleeding. The degree of shock found

in the patient is proportionate to the amount of the blood loss. Women with a possible placenta previa must be placed in a hospital for treatment. An adequate amount of blood must be available for transfusions. Rectal or vaginal examinations often precipitate a severe hemorrhage. Rectal examinations should not be made and vaginal examinations should be delayed until facilities are available for the treatment of the placenta previa. The diagnosis of a placenta previa can be made before delivery only if placental tissue can be felt covering, or bordering, the internal os of the cervix. If the patient is delivered vaginally, a major postpartum hemorrhage can be anticipated and preparations should be made to treat it. A cesarean section should not be done for a placenta previa unless the diagnosis has been confirmed by palpating the placental tissue through the internal os of the cervix because less than half of the patients with painless, causeless bleeding actually have a placenta previa.

The expectant plan of treatment may be utilized in patients with a possible placenta previa if the infant is still premature. This plan of treatment should be used only if hospital facilities and adequate blood for transfusions are available. Patients to be treated expectantly should not be examined rectally and no manipulations of the cervix should be made.

An abruption of the placenta is the most dangerous cause of bleeding in the last half of pregnancy. The bleeding is typically accompanied by a painful tetanic contraction of the uterus and fetal death. The degree of shock may be out of proportion to the amount of the blood lost. Preparation should be made to transfuse the patient before, during and after delivery if it should become necessary. After the patient's condition has been stabilized the treatment consists of inducing labor by the rupture of the amniotic membrane for a vaginal delivery. A maternal mortality of less than 2% can be anticipated. If the infant is alive at the time of admission to the hospital, 75% can be expected to be delivered alive.

REFERENCES

1. Doranth, K. Quoted by Eastman, Nicholson J.: Williams Obstetrics, (10th Edition), New York, 1950, Appleton-Century-Croft, Inc., p. 564.
2. Eastman, Nicholson J.: Williams Obstetrics, (10th

- Edition) New York, 1950, Appleton-Century-Croft, Inc.
3. Dippel, A. L., and Brown, W. H.: Roentgen Visualization of the Placenta by Soft Tissue Technique. *Am. J. Obst. and Gynec.* 40:986-994, 1940.
 4. Johnson, Herman W.: The Conservative Management of Some Varieties of Placenta Previa. *Am. J. Obst. and Gynec.*, 50:248-254, 1945.

5. Macafee, C. H. G.: Placenta Previa—A Study of 174 Cases. *J. Obst. and Gynaec. Brit. Emp.* 52:313-324, 1945.
6. McCain, J. R., and Poliakoff, S. R.: The Conservative Treatment of Premature Separation of the Normally Implanted Placenta. *J. A. M. A.* 141:513-517, 1949.

THE SOUTH CAROLINA HEART ASSOCIATION

The South Carolina Heart Association operates the following clinics for the medically indigent patients in our State:—S. C. Medical College, Charleston, Dr. John A. Boone; Columbia Hospital, Columbia, Dr. Warren Irvin; Spartanburg General Hospital, Spartanburg, Dr. William Nelson; Greenville General Hospital, Greenville, Dr. William Schulze; Conway Hospital, Conway, Dr. R. C. Smith; Wallace Thomson Memorial Hospital, Union, Dr. Paul Kent Switzer, Jr.; Tuomey Hospital, Sumter, Dr. C. H. White; Self Memorial Hospital, Greenwood, Dr. R. H. Christian; Colleton County Health Department, Walterboro, Dr. J. A. Boone; and Beaufort County Health Department, Beaufort, Dr. J. A. Boone.

The Charleston Clinic is engaged in advanced research in heart diseases in addition to catheterization and heart surgery, in all of which we have made splendid progress.

Dr. William Schulze, General Chairman of the Fifth Annual Meeting, arranged an outstanding program in Greenville in February, when outstanding authorities from various parts of the country spoke on pertinent topics. If you are not already a member of our Association, this is a cordial invitation to you to join. Dues are \$5.00 a year; H. M. McElveen, Executive Secretary, 203 Carolina Life Building, Columbia 1, S. C.

COMING MEETINGS

The Southeastern Allergy Association will meet in Atlanta on March 25, 26, 27, 1954. Dr. Katherine B. Mac Innis of Columbia is Secretary.

The Aero Medical Association holds its 25th Annual Meeting in Washington March 29 - 31, 1954.

POSTGRADUATE REFRESHER COURSES IN RHEUMATIC FEVER

The Rheumatic Fever and Cardiac Disease Committee of the American Academy of Pediatrics has been aware of the lack of postgraduate opportunities for the study of rheumatic fever or congenital heart disease for physicians who might desire to attend regularly organized courses, and believes that there may be a demand for this type of instruction. For 1954 it has attempted to stimulate the organization of *intensive 3-day refresher courses in rheumatic fever and rheumatic heart disease*, with major emphasis on the clinical aspects. If the response is good, it will try to expand this educational experiment.

The following courses are offered for 1954:

LA RABIDA JACKSON PARK SANITARIUM, Jackson Park at East 65th St., Chicago 49, Illinois. Hugh McCulloch, M. D., Director.

First course: March 31 through April 2, 1954.

Second course: October 7 through 9, 1954.

For further information or enrollment, please write to Dr. McCulloch.

HOUSE OF THE GOOD SAMARITAN, 25 Binney St., Boston 15, Massachusetts.

Benedict F. Massell, M. D., Director.

April 19 through 21, 1954.

For further information or enrollment, please write Dr. Massell.

Maximum number of students 15, minimum 10. Registration \$35. (All courses)

The courses are intended primarily for pediatricians, but they will also be open to any interested physicians—general practitioners or internists—who wish to apply.

Attention is called also to the more comprehensive courses in rheumatic fever to be offered in 1954: LaRabida Jackson Park Sanitarium, March 22 through April 2; and St. Francis Sanatorium for Cardiac Children, Roslyn, L. I., N. Y., June 7 through 18.

THE ATLANTA GRADUATE MEDICAL ASSEMBLY

will hold its annual meeting

February 22, 23, and 24, 1954 — Biltmore Hotel
Atlanta, Georgia

Registration Fee \$10.00

Among the distinguished guest speakers:

Dr. R. L. Sanders, Memphis; Dr. Lester R. Dragstedt, Chicago; Dr. Virgil S. Counsellor, Rochester, Minn.; Dr. J. W. McCall, Cleveland; Dr. R. Gordon Douglas, New York; Dr. Allan C. Barnes, Cleveland; Dr. Charles A. Doan, Columbus, Ohio; Dr. Edgar R. Pund, Augusta; Dr. Dorothy H. Andersen, New York; Dr. Carl Muschenheim, New York; Dr. Donald D. Matson, Boston; Dr. Elmer Belt, Los Angeles; Dr. Herman K. Hellerstein, Cleveland.

THE SOUTHEASTERN SURGICAL CONGRESS BIRMINGHAM ASSEMBLY, TWENTY-SECOND ANNUAL MEETING, MARCH 8, 9, 10, 11, 1954

This important meeting will be held at the Dinkler-Tutwiler Hotel in Birmingham.

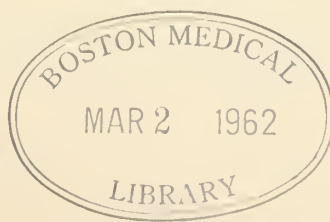
There will be panel discussions on traumatic lesions, esophagogastrintestinal hemorrhage, liver and gall-bladder pathology, and surgical management of peptic ulcer. The list of speakers is imposing and covers the whole country, with notable names too numerous to mention.

Speakers from South Carolina will be Dr. J. R. Young of Anderson, Dr. F. E. Kredel of Charleston, Dr. J. K. Webb of Greenville.

"Fifth Annual International Group of Doctors in Alcoholic Anonymous, Mayflower Hotel, Akron, Ohio, May 14, 15 and 16, 1954. For information and reservations address: Doctors, Mayflower Hotel, Akron, Ohio."

This group of doctors in AA was formed five years ago with a few men from Western New York State. Last year we had men present from as far south as Florida and as far west as Colorado. There are no doubt men in your state who would appreciate knowing about this meeting that we could not otherwise contact than through your medical journals.

H. D. Chamberlain, M. D.,
Chairman, 1954 Meeting of International Group of Doctors in AA



The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain Mullins
J. D. Guess Greenville
C. J. Milling Columbia
H. R. Pratt-Thomas Charleston

Vince Moseley Charleston
Ben Miller Columbia
W. H. Prioleau Charleston

G. D. Johnson Spartanburg
R. M. Pollitzer Greenville
Hugh Smith Greenville
Walter Mead Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)
Subscription Price

Charleston, S. C.
\$3.00 a Year

FEBRUARY, 1954

TWO SIDES OF PUBLIC RELATIONS

No one is likely to question the importance of maintaining satisfactory relations with the public, for the sake of ourselves as well as the sake of the public. So often has the matter been discussed that once in a while one finds a rebellious medical writer who feels that something should be done about the ways of the public as well as the ways of the profession. His thesis is apt to be that the public is a thoughtless, demanding, inconsiderate creature who disturbs unnecessarily the meals, the sleep, and the vitally necessary leisure time of the physician in order to satisfy its own whim and its sense of urgency about trifles.

There is no question but that such an element of the public thrives and probably in some degree always will persist. There is no doubt that the physician has to take an unnecessary beating from this class of people. Should he condemn his whole clientele for the stupid behavior of a part of it?

It is not likely that any real physician will be disturbed by answering calls which to him seem fruitless but which, he realizes, mean much in reassurance and comfort to patients. There have been suggestions that many nuisance calls might be eliminated if physicians in a community would agree to inform their patients that such calls are luxuries above and beyond the usual working activities of the physician, and that luxuries cost more than staples. If such an agreement could be made general and binding, it seems reasonable that much burden could be removed from the doctor. Unfortunately, it must be a general agreement to carry weight, and some medical com-

munities include too many temperamental members to make the rule easy of enforcement.

LEARN WHILE YOU RIDE

Elsewhere in this issue is published an account of a new type of medical educational material which will probably appeal to many physicians. It is a collection of tape recordings of current meetings and lectures, and should keep the practitioner abreast of the very last minute advances of medicine. A picture shows the busy doctor in his automobile listening intently to his record machine while he threads his way through the intricacies of traffic on his daily rounds.

There are certain considerations which may apply to this addition to the doctor's equipment. It might be thought that the distraction of the playing might be bad for a driver already subject to the many hazards of driving. It might be suspected that considerable editorial genius would be required to select the best material from a miscellaneous mass, and to find speakers whose delivery is clear and intelligible. Old hands at conventions know that not all the speakers are worth hearing and that not all of those who are heard are understood. Then, too, is not the required attentiveness adding a little more push to the many pressures which already assail the busy practitioner?

These are perhaps carping criticisms of a new experiment, which every man with a suitable pocketbook may make to his own taste. Somehow, there seems to be a long jump from the horse-and-buggy doctor who could spend his time in meditation and observation, and

perhaps even relaxation, to the modern fellow who has knowledge drummed into his ears above the screeching of brakes and the honks of horns. There are, no doubt, a few of us who would prefer to drive in such peace as is possible, and to save our energies for our ordinary mild vituperation of our errant fellow travelers.

PROFESSIONAL FEES AND PUBLIC RELATIONS

There is no doubt that professional fees can and do affect public relations and that much of the unpleasant attitudes toward doctors stems from reactions to the fees we charge. An analysis of 40 cases handled by the Kings County, N. Y. mediation committee in 1952-53 revealed that 6 cases resulted from a failure of the doctor to explain the costs of contemplated treatment and that in 4 additional cases, there occurred overcharging. Thus, one-fourth of the cases had to do with fees.

Cases that are actually referred to a mediation or grievance committee are a very small part of the cases of dissatisfaction and so have little value in indicating the true condition. However, there are many other indications that there is a widespread dissatisfaction with the size of fees charged, the failure to discuss the fee before elective treatment is undertaken, failure to itemize bills, and to explain charges made in addition to allowances by insurance contracts. Actually, it appears to me that the dissatisfactions are more prevalent among the well-to-do than among patients with moderate incomes.

The once widely accepted principle of "soak the rich to pay for the poor" is no longer accepted graciously by the rich and near rich, and it should be discarded. A service, just like a piece of merchandise, should have a certain intrinsic value, and its cost should not exceed that value simply because the customer is wealthy. It is quite true that the well-to-do patient and his family are likely to be far more demanding and to require more of the doctor's time and emotional energy, and these additional requirements should be reflected in the bill. A fair and just fee for the service rendered is quite in order, and the doctor should have little trouble in justifying such a

charge, even though it be much greater than his so-called minimum or average fee. However, it is neither good business, ethically just, nor can it be easily defended to charge an excessive fee simply because the patient can pay it.

There is much complaint that doctors accept insurance allowances as gravy and charge in addition the same fee as they would have charged had there been no insurance. How prevalent that practice is, I cannot say. Doctors do find that many patients are over-insured and that the sum of their insurance allowances exceeds the doctor's usual fee. This presents a great temptation to charge up to the limit of the insurance allowance. Actually, it is not good public policy to encourage or make it possible for patients to make a profit from illness. Neither does it seem fair to charge a fee commensurate with the income of a low-paid worker, when that fee will be far more than covered by the insurance payment.

From observation and experience in processing Physician's Reports in Blue Shield cases, I am convinced that by far the majority of South Carolina doctors are not guilty of gouging their patients. In those reports, the physician is requested to state his usual or regular fee for the service rendered. This information is not requested with the idea of spying into the doctor's personal fee schedule. It is requested to allow the Blue Shield Board to continuously compare its fee allowances with the regular fees of its participating physicians and to help the claims department fix a just allowance in cases of unusual nature or difficulties. Regardless of its objectives, it has also served secondly to show that there are certain doctors and certain medical centers whose fees as compared with those of other doctors appear to be excessive and at times deliberately padded. It seems to me to be a questionable practice to enter a charge for a hospital call, when that call is more or less social and to maintain contact with a patient whose medical care has been delegated to a colleague; or to charge for a daily call, just because one, in making rounds, drops in to say good morning. Further, I question the justice of the practice in some medical centers where specialization is fully carried out, for each

specialist concurrently treating a patient to charge his own usual fee, and often to continue his observation until the termination of hospitalization, even though that aspect of the problem for which he became responsible had long since been resolved.

In summary, patients and the public resent being overcharged; they resent being charged a fee more than that charged someone else who has had similar service; and they resent practices which they consider to be fee padding. This resentment is in part justified, but is more largely caused by lack of understanding or by misunderstanding. It can be eradicated more or less completely by a frank discussion and explanation of the fee for a contemplated service before the service is undertaken, and where indicated by an itemization of the charges made, and finally by an application of the golden rule in making charges for emergency cases where there is no opportunity to discuss fees before the service is begun. Most of our people are proud *to be able* to pay their doctors promptly—twenty years ago, many of them could not do so. That pride should be nurtured and maintained by setting fees that are within their reach.

J. Decherd Guess

BLUE SHIELD — BLUE CROSS

The South Carolina Medical Care Plan, our Blue Shield organization, belongs to the South Carolina Medical Association and is operated by a board of directors elected by the Association, under a set of By-laws adopted by it. The policies and methods of operation are subject to review, criticism and alteration by the Association. The Board constantly has these facts in mind and stands ready at all times to hear criticisms and suggestions, and it will willingly confer with any one member or group of members on questions relating to operation of the Plan.

Although owned and operated by the South Carolina Medical Association, the Plan is an altruistic, non-profit corporation, set up to serve primarily the people of the state rather than to serve its doctors. Many thinking doctors and laymen believe that Blue Shield and Blue Cross pose the greatest bulwark against socialized or state medicine.

Blue Shield and Blue Cross offer not just insurance but assurance as well. The service features of both plans assure their members with low incomes that their hospital and doctors bills, arising from the treatment of covered illness, will be paid *in full*. This is distinctive with Blue Shield and Blue Cross. It is made possible through the cooperation and participation of the doctors and the hospitals of the state. Over eleven hundred doctors and every recognized, accredited general hospital are participants. The cooperative non-profit plans do not fight or unjustly criticise commercial insurance companies. For many individuals, commercial insurance companies provide specific types of coverage, better suited to their particular needs. Many individuals are able and find it wise to supplement their Blue Shield—Blue Cross memberships with commercial insurance coverage.

Commercial insurance companies, since they must be a profitable investment for their stockholders, must decline or eliminate poor health risks, unless such risks are included in very large groups. Hence, they have to reserve the right of non-renewal and of termination of coverage at an attained age, usually 60 to 70 years.

Blue Shield—Blue Cross membership once attained, may be continued for life. Since no profit is necessary, underwriting standards are not so strict. However, even they have to guard against accepting as members persons who do not come in as *risks*, with the *probability* of loss, but who instead represent certain loss. Certain loss is not insurable. Therefore, very small groups and individual applicants are scrutinized rather closely to rule out certain losses, and waiting periods are applied to many frequently recurring or easily anticipated conditions. Diagnostic hospital admissions and examinations are not covered, because they are not insurable risks. Utilization could easily be universal. The individual seeking coverage of diagnostic examinations does not stand a chance of personal loss, while the insurance carrier would be subjected to the certainty of loss. To attempt to cover them would require a fee sufficient to pay the hospital and the doctor *plus* administrative costs. It is cheaper for the individual to pay such

fees direct to hospital and doctor.

Since our doctors own and control Blue Shield and since our hospitals and our doctors control Blue Cross, it is to be expected of them that they will protect the plans against deliberate abuses and those caused by misunderstanding; that they will encourage good relations with the people; that they will tactfully explain limitations in subscription agreements, guard against unnecessary utilization, unnecessary hospitalization and unnecessarily prolonged hospitalization. The less unnecessary expense incurred, the greater the benefits that can be offered to the subscriber.



Forty Years Ago

February 1914

An editorial on J. Marion Sims apropos of continued plans to erect a monument to him in Columbia—membership of the Association was 700—Papers on Typhoid Fever and on Blood Pressure, on the General Surgeon, and on Prostatic Obstruction.

At a meeting of the Spartanburg County Medical Society, Dr. Jeffries stated that in his twenty-five years of practice the two most difficult problems for him to handle were human nature and medical ethics—At a meeting of the Second District Association, Dr. William Weston read a paper on Infantile Scorbatus.

INSTITUTE FOR MOTHERS OF PRESCHOOL DEAF CHILDREN

An institute for mothers of preschool deaf children is being planned at Cedar Spring. The purpose of the institute is to give full information of a practical and technical nature on the guidance and training of the deaf child.

The institute will include the following:

1. The Small Deaf Child in the Home—Miss Josephine Prall, Hearing Consultant and specialist in the field of the education of the deaf.

This talk will deal with practical problems in the home and give advice on speech, hearing aids, auditory training, personality, and

other adjustments.

2. The Growth and Development of the Young Child—Dr. D. Lesesne Smith, School Pediatrician.

3. The Emotional and Mental Development of the Young Child—Dr. Robert Wingfield, School Psychologist.

4. The Education of the Deaf Child—Mr. N. F. Walker, Principal of the school.

This will include a tour of the school and an opportunity to see classroom work.

5. Experiences in raising deaf children. These talks will be given by two mothers of deaf children now enrolled at the school.

6. Diseases of the Ear Which Commonly Cause Deafness—Dr. Robert Ralston, School Otologist.

Considerable time will be given for discussions and private conferences with speakers and members of the school staff.

The institute for both white and colored mothers will probably last for two days. A definite date will be set when we have full information on those who desire to attend. Mothers and children—as many as we can accommodate — will be guests of the school without cost.

The only way we have of reaching those in need of this service is through the otologists and pediatricians of South Carolina and the county departments of public welfare.

It is our hope that all otologists and pediatricians will refer to us patients in need of this service.

With Mr. Rivers' kind permission, we are asking each county department of public welfare to make contact with the mothers of preschool deaf children and let us know how many are interested in attending the institute.

Laurens Walker, Superintendent
School for the Deaf and the Blind
Spartanburg, South Carolina

CORRESPONDENCE

LETTER TO THE EDITOR

Medical Association of Georgia

I would like to enlist your cooperation in a proposed transportation plan in connection with the 1954 AMA Convention, San Francisco, June 21-25.

The Moyers Travel Bureau, 34 Peachtree St., Atlanta, is arranging a scenic 8,000 mile tour—20 days of educative vacation with five days in San Francisco for the AMA Convention—hotels, trains and motor trips all reserved from June 13 to July 2—visiting the Canadian Rockies, Grand Canyon, California and Mexico—(See enclosed marked map showing planned route and enclosed itinerary of the tour). This special train for physicians will be called the "Southern AMA

Special." The charge for this all expense paid tour is \$445.00 (plus tax).

Mrs. Poer, my family and myself plan to make this trip and feel that some of our colleagues in our sister states in the Southeastern region would be interested in such a fine trip. Mr. Moyers has indicated that if in your opinion there is such interest evident among the physicians of your state, he would advertise this plan in your state medical journal, or howsoever you might advise.

Mr. Moyers offers a free trip to any agent securing 20 enrollments for the trip. If an agent secures less than 20 enrollments, \$10.00 will be paid for each enrollment.

I shall be very much interested to receive your reply and I cordially extend an invitation to the physicians of your state to join the Georgia doctors on this travel tour.

Cordially yours,

David Henry Poer, M. D., Editor,
Journal of The Medical Association
of Georgia

NEWS ITEMS

The Chester County Medical Society convened in its December meeting at the hospital, with the president, Dr. J. S. Redding, presiding.

The main business was the election of officers for 1954 which resulted as follows:

Dr. Malcolm L. Marion was elected president, succeeding Dr. Redding. Dr. A. J. Reinovsky of Great Falls was elected vice president, and Dr. Charles W. Brice, Jr., secretary and treasurer.

More than 260 Spartanburg area doctors and druggists and their wives attended a Country Club dinner dance on December 16.

Honored were officers and members of the Spartanburg County Medical Society and their wives.

Hosts were officers and members of the three-county Piedmont Pharmaceutical Association, composed of druggists in Spartanburg, Cherokee and Union Counties. Guests included the druggists' wives.

The city of Spartanburg, Woodruff, Pacolet, Chesnee, Lyman, Jonesville, Lockhart and Union were among areas represented at the event.

The first of these annual affairs was held in 1952 with the 75-member druggists' organization as hosts.

Among those attending were Dr. Charles Poole, president of the Medical Society, and J. M. Smith, Jr., president of the druggists' organization.

The Pickens County Medical Society has elected Dr. J. H. Jameson president.

Other officers elected to serve for 1954 are as follows:

Vice president, Dr. T. L. Valley, Pickens; secretary and treasurer, Dr. A. D. Couch, Easley; delegate to State Convention, Dr. J. A. White, Easley. Dr. Charlotte Kay of Liberty was named to serve on the Board of Censors for three years.

Dr. James A. McLeod, who has practiced medicine there since his discharge from the Army a year ago, will leave Florence for Orlando, Fla., where he will become associated in a practice of general and cardio

vascular surgery.

Dr. Robert Dennis Hill of Pacolet was named Spartanburg County Doctor of the Year.

Dr. Hill is the fifth physician to be selected for the honor by the County Medical Society. The award was revealed at the annual meeting of the group.

The annual selection is done by secret ballot and the doctor selected does not know of the honor until it is announced at the annual meeting.

Dr. Hill, a native of Bishopville, has been a general practitioner at Pacolet for 27 years. During this time he was the only doctor within a 10-mile radius except for eight years.

Dr. Henry Ross was elected president of the Greenville General Hospital Medical Staff for the coming year at the annual staff meeting last week. He succeeds Dr. Cecil White.

Also elected for a one-year term were Dr. William Schulze, vice president and Dr. Tom Furman, secretary.

Dr. Eugene Yeargin is outgoing vice president and Dr. Charlie Thomas outgoing secretary.

Dr. W. C. Bolt has been named president of the Anderson County Medical Society to succeed Dr. Allen Brabham.

Elected to serve with Dr. Bolt are Dr. J. H. Hancock, vice president; Dr. Henry Hearne, treasurer; and Dr. James G. Halford, secretary.

Delegates elected to attend the state convention were Dr. James B. Latimer, Dr. Ned Camp, and Henry Jordan.

Dr. A. B. Weathersbee has started the practice of medicine in Bishopville. He will be affiliated with Beach Drug Company, and for the time being, will have his office in the rear of the drug store.

Dr. Weathersbee comes to Bishopville from Columbia after having been in the United States Army since graduating from the medical college in Charleston.

WILLIAMSBURG COUNTY MEDICAL SOCIETY

December 17, 1953

Williamsburg County Medical Society had a special meeting (ladies night and Christmas party) at the office of Dr. Michael Holmes, Kingstree, S. C.

After a delightful social hour, which included a magnificent barbecue supper, the Society was addressed by Dr. Wilson Ball of the State Board of Health concerning a mass Venereal Disease Survey of Williamsburg County by the Health Department. Dr. Ball presented several plans for carrying out this survey. The society adopted a plan whereby all luetic cases found during the survey will have the privilege of choosing treatment either at the Health Department or his or her local physician. Following Dr. Ball's address an instructive motion picture was shown by a representative of the Lederle Laboratories on Varidase in the treatment of chronic ulcers, burns and draining cavities.

The Society was reminded that its next meeting will be held in January for the election of officers and delegates to the S. C. M. A. Convention.

V. L. Bauer, M. D., Secretary & Treasurer

The Coastal Medical Society held its December 17th meeting at the Southland Restaurant in Walterboro. Program for the evening included the social hour from 6 to 7 p. m., followed by dinner, after which the business and scientific session was begun.

Speaker for the meeting was Dr. John A. Boone, Professor of Medicine and Cardiology, Medical College of South Carolina. His subject was: "Management of Arterial Hypertensive Disease."

The secretary for the Society, Dr. H. M. Carter, Walterboro, stated that the January meeting would be held in St. George.

The Greenville County Medical Society has elected officers to serve during 1954. Dr. Perry T. Bates was named president-elect, which means he will take over the chief office in the society in 1955. Dr. Asa M. Scarborough, who was president-elect during 1953, will serve as president during 1954. Other officers are Dr. H. M. Whitworth, Jr., vice-president; Dr. W. H. Powe, Jr., secretary, and Dr. W. W. Goodlett, treasurer. Dr. Scarborough succeeds Dr. J. M. Fewell as president.

City Council appointed Dr. R. C. Alverson to the Greer Board of Health at the December meeting.

Dr. Dan F. Mooror is moving to Latta and will set up temporary offices in the new Health Center building.

Dr. Julian Price will take part in the discussions at the Ninth National Conference on Rural Health in Dallas on March 4-6.

Delegates and alternate delegates to the American Academy of General Practice Meeting for 1954.

The delegates are Dr. William H. Speissegger of Charleston, and Dr. Charles N. Wyatt of Greenville. Alternate delegates are Dr. Keith Sanders of Kingstree, and Dr. Homer M. Eargle of Orangeburg.

The Horry County Medical Society met at Pine Lakes Inn at Myrtle Beach on Tuesday, Jan. 12, 1954. The Myrtle Beach physicians were hosts to the other members and a delightful dinner was served. The program consisted of a talk by Dr. George Smith on "Practical Aspects of Skin Diseases."

An election of officers for 1954 was held and Dr. Paul Sasser was elected president. Dr. Stan Collins was elected Secretary-Treasurer. A motion was passed that a ladies auxiliary be formed for Horry County. The Horry County Society meets three times a year with the Loris, Conway, and Myrtle Beach groups of physicians alternating as hosts. The next meeting will be held in Conway in March.

The Conway Hospital is pleased to be able to open its new additions boosting its bed capacity to 93 along with new administrative offices. Plans are under way to renovate the old wings and enlarge and improve the laboratory and emergency room facilities. These additions have long been needed and are already operating at full capacity.

Ten universities, colleges, and hospitals benefited from recent grants to support research projects, made by Eli Lilly and Company. Among the institutions receiving Lilly grants:

Medical College of South Carolina, Charleston, South Carolina: Dr. Leon Banov, Jr., associate in surgery; study of the effects of antibiotics on common anorectal inflammatory lesions.

Medical College of South Carolina: Dr. M. W. Beach, professor of pediatrics; study on the effectiveness of 'Ilotycin' (Erythromycin, Lilly) in the treatment of diphtheria and diphtheria carrier state.

The Annual Meeting of the Columbia Medical Society for the election of officers was held in the Crystal Room of the Hotel Columbia on December 14, 1953. The President, Dr. George T. McCutchen, presided over the meeting.

The results of the election were as follows: President, Dr. D. F. Adcock; Vice-President, Dr. John Holler; Secretary, Dr. Giv Castles; Treasurer, Dr.

E. W. Masters; Editor of the Recorder, Dr. C. R. Holmes; Member of the Board of Censors, Dr. Gerald W. Scurry; Member of the Public Relations Committee, Dr. A. E. Cremer; Delegates to the South Carolina Medical Association: Dr. Wm. C. Cantey, Dr. H. W. Moore, and Dr. Richard Josey; Alternate Delegates: Dr. Weston Cook and Dr. Tucker Weston.

PROGRAM

FIFTY-FIFTH ANNUAL MEETING TRI-STATE MEDICAL ASSOCIATION Charleston, S. C., February 22 and 23, 1954 Headquarters—Francis Marion Hotel

Chairman, Program Committee,
Dr. Frederick E. Kredel
Chairman, Committee on Arrangements,
Dr. I. Ripon Wilson, Jr.
Monday, February 22, 1954
9:30 A. M.

CALL TO ORDER, INVOCATION, WELCOME, AND ANNOUNCEMENTS 10:00 A. M.—SYMPOSIUM ON NEURO-PSY- CHIATRY

Moderator: Dr. Jennings J. Cleckley, Assistant Professor of Neuro-Psychiatry, Medical College of South Carolina, and Director, Mental Hygiene Clinic.

The Treatment of Hypochondriasis: Dr. Ewald W. Busse, Professor and Head, Department of Neuro-Psychiatry, Duke University. Formerly Head, Division of Psycho-Somatic Medicine, University of Colorado.

Sub-Insulin Shock in Mild Nervous Conditions: Dr. William Ray Griffin, Jr., Appalachian Hall Sanitarium, Asheville, North Carolina.

Use of Ancillary Psychiatric Personnel and Community Resources in Treatment: Dr. Joseph B. Parker, Associate Professor of Psychiatry, Duke University, and Chief, Psychiatric Service, V. A. Hospital, Durham, North Carolina.

Discussion:

11:15 A. M.—PANEL ON TRAUMA

Moderator: Dr. John A. Siegling, Professor of Orthopedic Surgery, Charleston, South Carolina.

Injuries to the Cervical Spine: Dr. W. Gayle Crutchfield, Professor and Head, Department of Neuro-Surgery, University of Virginia, Charlottesville, Virginia.

Fractures of the Humerus: Dr. Charles B. Thomas, Greenville, South Carolina.

Discussion:

12:15 P. M.—ATOMIC MEDICINE

Rear Admiral Charles F. Behrens, MC, USN, District Medical Officer, Sixth Naval District.

1:00 P. M.—RECESS FOR LUNCHEON

2:30 P. M.—Clinical Demonstrations by Faculty of Medical College of S. C., Baruch Auditorium (six blocks west of hotel).

The Medical College in Service to the Practitioner: Dr. Kenneth M. Lynch, President and Professor of Pathology.

2:40 p. m.—Malignant Potentialities of Breast Lesions: Dr. John T. Cuttino, Dean and Professor of Pathology.

2:50 P. M.—CINE CLINICS:

Excision of Varicose Veins: Dr. W. H. Prioleau, Clinical Professor and Dr. J. M. Stallworth, Instructor in Surgery.

Fibrillation and Defibrillation of the Heart: Dr. John A. Boone, Professor of Medicine.

3:10 P. M.—Pulmonary Function Studies: Dr. Kelly T. McKee, Assistant Professor of Medicine.

3:20 P. M.—Medical Case: Dr. Vince Moseley, Professor of Medicine.

3:30 P. M.—Laboratory Diagnosis of Virus Diseases: Dr. H. Goldberg, Assistant Professor of Bacteriology.

3:40 P. M.—Emergency Gastrectomy for Bleeding and Perforated Peptic Ulcer: Dr. H. W. Mayo, Jr., Assistant Professor of Surgery.

3:50 P. M.—Indications for Fenestration Operation—Results: Dr. G. W. Bates, Instructor in Otolaryngology.
 4:00 P. M.—Cytologic Diagnosis of Sputum in Cancer of Lung: Dr. H. R. Pratt-Thomas, Professor of Pathology.
 4:10 P. M.—Primary Operation for Cancer of Cervix: Dr. L. L. Hester, Associate in Obstetrics and Gynecology.

4:20 P. M.—Cancer of Oral Cavity: Dr. John C. Hawk, Director, Cancer Clinic.

4:30 P. M.—Plastic Surgery of the Face: Dr. Robert F. Hagerty, Associate Director, Cancer Clinic, and Instructor in Plastic Surgery.

4:40 P. M.—Radioactive Iodine Tracer Studies in Cancer of the Thyroid: Dr. H. K. Ezell, Instructor in Chemistry.

4:50 P. M.—Visits to Laboratories and Hospital.

RECESS

7:00 P. M.—Social Hour.

8:00 P. M.—ANNUAL BANQUET.

Toastmaster: Dr. Frederick Kredel, President-Elect.

Address of President: Dr. H. Grady Dixon.

Guest Speaker:

Tuesday, February 23, 1954

9:30 A. M.—Value of Hypotensive Drugs in the Treatment of Essential Hypertension: Dr. Ralph R. Coleman, Charleston, South Carolina.

10:00 A. M.—The Post-Graduate Program for General Practitioners: Dr. John R. Bender, Winston-Salem, North Carolina, Secretary, North Carolina Academy of General Practice.

Discussion by Dr. R. B. Davis, Greensboro, North Carolina and Dr. Wyman King, President, South Carolina Academy of General Practice.

10:30 A. M.—*Pediatric Panel*: Prevention and Treatment of Accidental Poisoning in Infancy and Childhood:

Moderator: Dr. J. I. Waring, Associate Professor of Pediatrics, Medical College of South Carolina.

Accidental Poisoning in Children: Dr. Jay M. Arena, Duke University, Durham, North Carolina.

Recent Cases of Poisoning in Children: Dr. Lee E. Sutton, Jr., Medical College of Virginia, Richmond, Virginia.

Discussion.

11:30 A. M.—*Medical Topics of Interest to the General Practitioner*:

Anti-Cholinergic Drugs in the Treatment of Peptic Ulcer: Dr. T. Neill Barnett, Richmond, Virginia.

Amebiasis: Dr. George R. Wilkinson, Greenville, South Carolina.

Venom Poisoning and its Treatment: Dr. L. J. Taubenhaus, Charlotte, North Carolina.

Discussion.

12:30-2:00—RECESS FOR LUNCHEON:

2:00 P. M.—*Panel on Surgical Topics*:

Recent Advances in the Surgery of Major Arteries: Dr. Lewis H. Boshier, Jr., Medical College of Virginia, Richmond, Virginia.

2:20 P. M.—Adrenalectomy in Recurrent Breast Cancer: Dr. John K. Webb, Greenville, South Carolina.

2:40 P. M.—Retroperitoneal Fibrolipoma: Dr. Russell Buxton and Dr. A. A. Creecy, Newport News, Virginia.

3:00 P. M.—Adenoma of the Thyroid: Dr. Furman Wallace, Spartanburg, South Carolina.

Discussion.

3:30 P. M.—Alcoholism: Dr. C. R. F. Baker, President, South Carolina State Medical Association, Sumter, South Carolina.

4:00 P. M.—What Medicine Can Give: Dr. Julian P. Price, Member, Board of Trustees, A. M. A., Florence, South Carolina.

Discussion: Dr. J. I. Waring.

4:30 P. M.—Business Meeting—Election of Officers.

8:00 P. M.—Combined Meeting with Charleston

County Medical Society, Baruch Auditorium, Medical College of South Carolina.

Help for the Hearing Handicapped: Dr. Gordon D. Hoople, Professor Emeritus of Otolaryngology and Medical Director, Hearing and Speech Center, Syracuse University, Syracuse, New York.

AUDIO DIGEST—MEDICAL LIBRARY ON TAPE

Back in the horse and buggy days, the doctor kept up with the medical journals of the day by reading as he drove from call to call. Old Dobbin kept a watchful eye on the traffic.

Today, however, with more magazines and less time for reading, the general practitioner is hard pressed to follow the latest developments. No longer can he read as he drives, for the high-powered automobile needs a hand on the "reins" and a watchful eye on the road.

Nevertheless, the fact that the only non-productive time in many a doctor's day is time spent in his car rang a bell with Jerry Pettis, public relations man for the California Medical Association. If reading was out of the question, why couldn't the doctor listen?



Pettis decided he could, and Audio Digest—summaries of current medical literature on magnetic tape—was born. Issued on hour-long reels of "Scotch" sound recording tape, the new publication featured approximately 30 digested articles weekly selected from some 1,900 publications every month, covering the entire field of medicine with special emphasis on articles of value to general practitioners.

The recordings could be listened to during moments of relaxation, on a tape recorder at the office or home, or on specially engineered tape recorders for listening while driving.

Narrated in terse, listenable form, Audio Digest dealt with ideology, diagnosis and treatment, "tuned to the ear for everyday application in the office and hospital," each article authenticated with title, author and reference.

In December, Audio Digest was turned over by Pettis to the California Medical Association. This group voted to establish the Audio Digest Foundation—a subsidiary, non-profit corporation—as a means of summarizing and distributing current medical litera-

ture on magnetic tape to doctors throughout the world.

A new technique will be instituted making it possible to provide tape recordings in many foreign languages, so that the doctors in other countries will be able to listen to the progress of medicine in America in their native tongue.

Three types of service will make Audio Digest of equal value to the specialist, the general practitioner and the medical student. These services will be:

1) Continuation of the weekly, one-hour tape summarizing the current medical literature for the general practitioner. Subscription price runs \$2.75 a week and the tape recordings may be kept for permanent reference.

Starting January 15, a bi-weekly, one-hour tape will be available for surgeons. Starting February 15, a similar service for specialists in internal medicine will be provided. March 15, is the beginning date for a tape-digest for obstetricians and gynecologists.

2) A complete medical lecture library is being compiled from on-the-spot recordings made at medical conventions, for sale or rental.

3) Master lecture tapes from the nation's 79 medical schools will be made available to medical school libraries and reviewed each six months to be kept up to date.

Major General Silas B. Hays, Army Medical Corps has approved a pilot plan using this media in both the United States and overseas medical-military installations.

Dr. Sidney J. Shipman, San Francisco, chairman of the California Medical Association's Council commented, "By making medical literature and lectures available to the world's physicians in their own language and in this new dramatic form, we hope to contribute something to medical education."

He concluded "This will be a special boon to the doctor practicing in rural or isolated areas because it will take the profession's outstanding teachers to him when it is impossible for him to go to the medical center to hear the professor. This means that the

rural doctor can keep abreast of medicine's rapid scientific advances and at the same time, continue home care for his patients."

Additional information on the new tape recorded material can be obtained by writing Audio Digest, c/o California Medical Association, 417 S. Hill Street, Los Angeles 13, California.

DEATHS

DR. R. O. McCUTCHEN

Dr. R. O. McCutchen died recently at Lee County Memorial Hospital after a prolonged illness.

He was born Nov. 11, 1880, son of the late W. C. McCutchen and Elma E. Bradley McCutchen of Lee County.

He was graduated from the University of South Carolina in 1903. He was an honor graduate of the School of Medicine, University of Maryland, in the class of 1907, and started practicing in Bishopville that year. For 28 years, he was a trustee of the University of South Carolina, during which time he served as both vice chairman and chairman of the board. In 1916-1918 he was a member of the Selective Service Board and medical examiner of selectees. From 1935-1950 he was county physician for Lee County. Since 1938, he was railroad surgeon for the Atlantic Coast Line Railroad.

From 1942 to 1946, he was chairman of the Anti-Tuberculosis Association of Lee County. He was a member and past president of the Lee County Medical Association. He was chairman of the board of trustees of Bishopville public schools from 1910 to 1922.

Other public services and business interests have also laid claim to his time. He was for 14 years state director of the Cotton Cooperative Association, among the busiest years of that organization and state director of the American Cotton Cooperative Association from 1938 to 1941. For eight years he was mayor of Bishopville.



WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. David A. Wilson, Greenville, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

NATIONAL BOARD OF DIRECTORS RECOMMENDS TWO NEW PROJECTS

With the approval of the American Medical Association, the Board of Directors of the Woman's Auxiliary is recommending to all Auxiliary members for their support and cooperation *as individuals*, two important projects being promoted by (1) The National Foundation for Infantile Paralysis and (2) The American Heritage Foundation:

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS VACCINE VALIDITY STUDY

A nationwide study to determine the effectiveness of a polio vaccine in preventing paralytic polio will get underway in one or more southern states (approximately 200 counties) during the week of February 8, 1954 and ending June 1, 1954. During that time 500,000 to 1,000,000 school children of the second grade will have taken part in this study. Participation will be on a voluntary basis with the consent of the child's parents or legal guardians. The study will be conducted by the National Foundation with local health officers in charge. Local physicians will administer the injections.

Volunteers from the National Foundation's 3,100 chapters, covering every county in the United States,

will help in organizing and manning the study in local areas. Auxiliary members will be called upon to assist in this project in this capacity. As stated above, the American Medical Association feels that Auxiliary members can make a very worthwhile contribution to this important and meritorious project by participation *as individuals* on a local level with the groups who are serving as volunteers in this study.

TEN WAYS TO KILL AN AUXILIARY

1. Don't go to the meetings.
2. If you go, go late.
3. If the weather doesn't suit you, don't think of going.
4. If you do attend a meeting, find fault with the work of the officers and members.
5. Never accept office. It is easier to criticize than to do things.
6. Get sore if you are not appointed on committees; but if you are, do not attend committee meetings.
7. If asked by the chairman to give your opinion on some matter, tell her you have nothing to say. After the meeting tell everyone how things should be done.
8. Do nothing more than absolutely necessary, but when members use their ability to help matters

along, howl that the organization is run by a "clique".

9. Hold back your dues, or don't pay at all.

10. Don't bother about getting new members. . . .
"Let somebody else do it". (Borrowed)

CONVENTION CHAT

The annual convention will be held at the Ocean Forest Hotel, Myrtle Beach, May 11, 12, and 13. The presidents of the Auxiliary to the American Medical Association and of the Southern Auxiliary, Mrs. Leo J. Schaefer of Salina, Kansas and Mrs. George D. Feldner of New Orleans, La., respectively, have been invited as guests of the state auxiliary to attend the convention.

The convention chairmen are working on plans for many pleasant surprises at the meeting, including a lovely luncheon at Pine Lake Inn.

All members of the Auxiliary are urged to make plans to attend the festivities.

CRUSADE FOR FREEDOM

Adopted and promoted by the American Heritage Foundation

This project—THE CRUSADE FOR FREEDOM—is the officially adopted program of the American Heritage Foundation for the year 1953-54. Its objective is to act as a public information agency and principal fund raiser for the National Committee for a Free Europe, Inc. Through Radio Free Europe and other facilities the public funds raised by the Crusade will be used to conduct programs of hope, aid, encouragement and information to and on behalf of the captive countries of Eastern Europe. Radio Free Europe programs are sent behind the Iron Curtain . . . and they get there. They are designed to refute Communist lies and to bolster the morale of the oppressed

citizens. The Crusade for Freedom makes these broadcasts possible and thus gives every American the opportunity and privileges of participating in what the American Heritage Foundation regards as one of the most exciting, inspiring and successful offensives being conducted anywhere in behalf of human freedom.

THE CRUSADE FOR FREEDOM program will get under way in February 1954. The A. M. A. advisory council to the Woman's Auxiliary approved of the participation of the Auxiliary in this notable and outstanding project. As an organization, the Auxiliary can assist in the educational aspect of the program. As individuals, Auxiliary members can contribute in a financial way.

Background information about the American Heritage Foundation: This is a non-partisan, non-political educational organization functioning in the interests of a higher level of citizenship throughout the United States. It sponsored the Famous Freedom Train and the recent Non-partisan Register and Vote Campaign. A Board of Trustees, consisting of leaders in fields of labor, industry and education heads the Foundation. Henry Ford, II is chairman of the Board and Thomas d'Arcy Brophy is president of the Foundation.

TODAY'S HEALTH

DOCTORS WIVES NEED A SUBSCRIPTION

Probably no lay person is asked more questions about health problems and medical subjects than the wife of a physician. And, except for her husband, she can find no better source to give her the correct answers than the pages of TODAY'S HEALTH. Most physicians, like all husbands, would rather talk about other things than their profession or business, when off duty at home; so you can relieve your husband of much of this "shop talk" by keeping yourself informed through the pages of TODAY'S HEALTH.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

THE PRESIDENT'S HEALTH MESSAGE

President Eisenhower's special message on Health matters was delivered to Congress on January 18, 1954. It contained five specific recommendations, four of which are either new or represent a departure from the policy which has been followed in the past.

They are:

1. Continuation of present Federal programs for the protection and promotion of the general health of the people. Most of the programs referred to, if not all, are those administered under the newly created department of Health, Education and Welfare.

2. The creation of a Federal corporation to be launched with a capital of \$25,000,000 provided by the Government, for the reinsurance of risks assumed by hospital and health insurance organizations, both commercial and non-profit.

3. A formula for grants-in-aid programs designed to make these generally more uniform.

4. Substantial increase in the provision for rehabilitation of the physically handicapped.

5. Amendment of the Hospital Survey and Construction Act so as to authorize the construction thereunder of medical care facilities other than general hospitals.

Actually there is little really new about the pro-

posals and nothing which represents any drastic departure from the policy of the Federal government either in effect or proposed within the past decade. The one feature which is receiving substantial support from the White House for the first time, is that for the establishment of a reinsurance corporation to be financed by the Federal Government. With this exception, it seems that the President's proposals represent suggestions for curing some of the defects and for the improvement generally, of plans and programs already in effect and launched several years ago.

The proposals to continue the programs now being administered by the Department of Health, Education and Welfare, will probably receive little opposition or pointed criticism. The same is undoubtedly true of the effort to achieve some uniformity in the method of handling grants-in-aid to the various states. The President's point is well taken that "categorical grants have restricted funds to specified purposes, so that states often have too much money for some programs and not enough for others." His simplified formula for improving this situation includes three features:

1. The states would be aided in inverse proportion to their financial capacity.

2. The states would be helped in proportion to their

population.

3. A portion of the Federal assistance would be set aside for the support of unique projects of more than state-wide significance.

The chief criticism voiced in the past of the Hospital Survey and Construction (Hill-Burton) Law has been that it required the hospitals built thereunder to measure up to such high standards that the cost was raised unnecessarily and out of all proportion to the need required to furnish adequate care. It would seem, therefore, that the President's proposal to amend this law so that less pretentious institutions may be constructed should meet with general approval. Among the specific recommendations in this respect are these:

1. Increased assistance in the construction of non-profit hospitals for the care of the chronically ill.

2. Assistance in the construction of non-profit medically supervised nursing in convalescent homes.

3. Assistance in the construction of non-profit rehabilitation facilities for the disabled.

4. Assistance in the construction of non-profit diagnostic or treatment centers for ambulatory patients.

Provision for Federal assistance on a sound basis to the states for making surveys to determine their need in these respects is included in the recommendations.

Certainly the President has hit upon some of the principal weak points in the provisions for the care of the ill and physically disabled. Some of his statistics with respect to the need for additional general hospital beds probably will not meet with the general agreement. There can be no question, however, of the necessity for additional facilities in the categories for which he specifically recommends additional aid.

The two features of the health message which may provoke controversy are those in reference to additional provisions for rehabilitation of the physically disabled and for the establishment of a reinsurance corporation. The President goes along whole-heartedly with the views of the two former administrations that extensive effort to assure health facilities and medical care of all the people available, is an obligation of government. For those who do not agree with this proposition, there is little consolation to be found in the pronouncements of this administration. We like the idea that it should be a part of the Government's responsibility, but whether we like it or not, the policy has been adopted, we are well on the road toward carrying it out, and the prospect is that it will continue to grow and go forward in some way. Therefore, the questions presented by the suggestions of the President, are:

1. How far shall the Government go in discharging its obligations and responsibility in this regard?

2. Are the proposals sound?

3. Will they accomplish the desired purpose?

Now so far as the rehabilitation of the physically handicapped is concerned, the proposal for expanded Federal assistance in this respect in the provision of additional facilities to carry out the purpose, the President states that this should be done in the interest of the nation's economy and security as well as by

way of alleviating the personal discomfort of the individuals involved. According to his figures, in the present rehabilitation programs, 60,000 disabled individuals are being returned annually to productive lives while 250,000 are being disabled each year. We are, therefore, losing as a nation the productive efforts of 190,000 people. Under the plan for progressive increase in the services toward rehabilitation, Mr. Eisenhower envisions a goal whereby during the next five years a total of 660,000 disabled people may be returned "to places of full responsibility as actively working citizens." The following expressions from his message are worthy of note. "Considerations of both humanity and national self-interest demand that steps be taken now to improve this situation. Today, for example, we are spending three times as much in public assistance to care for non-productive disabled people as it would cost to make them self-sufficient and tax-paying members of their communities."

"Rehabilitated persons, as a group, pay back in federal income taxes many times the cost of their rehabilitation." "There are no statistics to portray the full depth and meaning in human terms of the rehabilitation program, but clearly it is a program that builds a stronger America."

The message contained no specific recommendation with respect to the amount of additional money which would be involved in the expansion proposed nor actually as to the manner in which it would be carried out except so far as it deals with the amendment of the Hospital Survey & Construction Act referred to above so as to provide for the construction of "non-profit rehabilitation facilities for the disabled." The response to this proposal will necessarily be determined to some extent, by whatever specific plans are suggested to carry it into effect.

That leaves only to be considered the proposal for the reinsurance corporation, and this may well prove to be the most controversial of Mr. Eisenhower's suggestions.

Introducing his remarks in this connection, the President expressed what has been the view of the medical profession and many people for a number of years.

"The best way for most of our people to provide themselves the resources to obtain good medical care is to participate in voluntary health insurance plans." He went on to state that hospitalization insurance, the type of health coverage most purchased, already meets approximately forty per cent of all private expenditures for hospital care. He believes that better health insurance protection for more people can be provided, that the progress already made in this field indicates that the voluntary organizations can reach many more people and provide better and broader coverage and that they should be encouraged and helped to do so. Mr. Eisenhower specifically stated that, "The government need not and should not go into the insurance business to furnish the protection which private and non-profit organizations do not now provide." But he thinks that government can and

should work with them to study and devise better methods of meeting the public need.

To this end, he suggested the formation of a "limited Federal reinsurance service" with the purpose of encouraging private and non-profit health insurance organizations "to offer broader health protection to more families." His idea is that the service would re-insure the special additional risks involved in such broader protection, and that the \$25,000,000 fund provided initially by the government would be retired from reinsurance fees obtained from the commercial companies and non-profit plans which participate.

The principle thus suggested is apparently the same as that embraced in the Wolverton Bill introduced in Congress last session by C. A. Wolverton, who is Chairman of the Interstate and Foreign Commerce Committee of the House of Representatives. The Bill made no progress last year, but has been reintroduced and currently is serving as a basis for discussion, with the result that there has been already considerable development of expression along the line suggested in this portion of the President's Health message.

Certain observers have compared the proposed corporation to that set up under the Roosevelt Administration for the purpose of insuring bank deposits. From the scant information already available, it seems logical to believe that the proposal could follow generally this plan and if it does so, there would appear to be little, if any, objection to it. The F. D. I. C. has unquestionably served a useful purpose and is almost universally popular.

The idea has, however, already received favorable comment from certain quarters which, in the past, have been opposed strongly to the views of the organized medical profession. Dr. Paul Magnuson who headed President Truman's commission on National Health, made statements before the Committee last week which appeared to indicate his favorable attitude. Certain labor leaders have testified strongly in support of the Wolverton Bill but these expressions, we do not think, should necessarily have the effect of damning the entire proposal without further full investigation as to just what would be involved.

Our reaction, at the moment, is not one of enthusiasm, but it is based primarily upon the doubt that such a corporation would go very far in accomplishing improvement in the situation. It is true that Blue Cross, Blue Shield and the commercial health and hospital insurance plans are lacking in sufficient actuarial experience with respect to catastrophic illness and wider coverage, to yet determine just how far they can go in these fields and remain in sound financial condition. To this extent, apparently the government would be in position to offer opportunity for experimentation which probably could not be found elsewhere.

All insurance would remain on a voluntary basis, the premiums would be paid by the individuals insured and the reinsurance fees by the non-profit plans and commercial companies. Undoubtedly, premiums for additional coverage and particularly for catastrophic

cases would be higher, and this fact would seem to eliminate the probability of adequate coverage on the lowest financial levels which, it seems, is the place where additional insurance protection is needed.

The Wolverton Bill which may or may not prove a pattern for the plan proposed by the President, would require private plans to adjust subscription rates to subscriber's incomes. People with bigger incomes would pay bigger fees. Whether or not such a plan is sound, it is difficult to say at this time.

In any event, President Eisenhower has made a suggestion for moderate development and expansion in the insurance field. On a voluntary basis, with the Government involved only to the extent of guaranteeing financial security as is done under the F. D. I. C. and the F. H. A. policies, we believe his suggestion deserves thoughtful, careful and unprejudiced consideration, and that all groups in the country interested in improving health and medical care, will be inclined to give it that sort of attention.

"THE HUMANITIES"

An editorial appearing in the December 1953 issue of the Connecticut State Medical Journal emphasizes, we think, a phase of medical (or for that matter, any other professional) education, which may have been greatly overlooked in recent years. Under the title "The Humanities and Medicine" the writer states that: "Medical educators the world over are giving increasing attention to the desirability of premedical cultural education rather than a preliminary curriculum overloaded with science." He refers to three points in the study of education at which this thought, in one form or another, has recently been expressed, and quotes at length from the remarks of one of the speakers at the International Conference on Medical Education. T. E. B. Howarth, second master, Winchester College, England, remarking upon the previous belief that science (and perhaps particularly Medical Science) "was in itself sufficient, if it maintained its rate of progress, to solve nearly all human problems," stated:

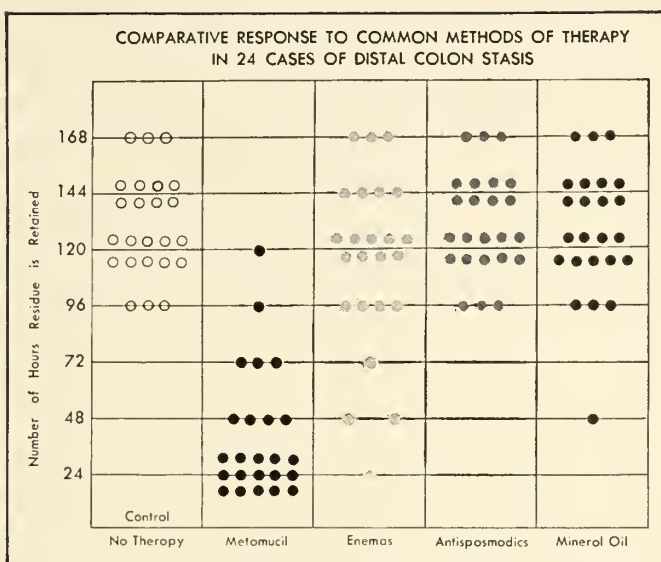
"The problem now, as we all see, is not only to ensure that Science directs Humanity, but to enable Humanity to direct Science," and he continued:

"There are, let us never forget, educational or dis-educational agencies antecedent to the school and continually influencing it. The family, political organization, journalism, entertainment and applied Science amongst others. To take just two examples—while a school may be teaching a child to read, his television set will almost certainly be teaching him not to read. Or again from philanthropic motives, a society may be so anxious to educate so many of its future citizens so highly that exceptional talent may be denied its proper opportunity.

"It is my contention that higher education is not even effectively vocational or utilitarian unless it has something to say in the classroom about ethical and aesthetic systems and also categories of truth not susceptible to scientific analysis.



Distal Colon Stasis



Management of Distal Colon Stasis with Metamucil®

The "irritable colon" resulting in distal colon stasis is a hard-to-manage by-product of many abdominal or stress conditions.

Roentgen evaluation of the commonly used methods to combat colonic stasis has shown the value of Metamucil because of its lack of irritation and its high degree of effectiveness* in this most prevalent type of stasis.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It produces smooth fecal bulk necessary to incite the normal peristaltic reflexes, without causing irritation, straining, impaction or interference with the

digestion or absorption of vitamins.

The average adult dose is one teaspoonful of Metamucil powder in a glass of cool water, milk or juice, followed by an additional glass of fluid if indicated. This amount of fluid is essential for the production of "smoothage."

It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

SEARLE Research in the Service of Medicine

*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis. *Rev. Gastroenterol.* 19:154 (Feb.) 1952.

"Both the strategy and the tactics of the problem must be bold and vigilant. I am afraid it is true that in some of the more reputable schools of this country one can still see little knots of dedicated and enthusiastic scientists sitting in dejected groups for two hours a week enduring a not very laborious subject called perhaps 'un-specialist French.' Strange, uncouth Anglo-Saxon sounds emerge from truncated and annotated excerpts from 'Les Miserables.' (It is perhaps only fair to add that a little further along the corridor may be found embryonic philosophers and historians demonstrably failing to appreciate either the beauty or utility of dog-fishes or iron-filings.)

"I think too there must be some history. There usually is but it is generally of the wrong sort. Too often the young scientist is subjected to an undignified scramble through century after century of what is known as 'outline' history, from which in fact no outline of any sort emerges. It is all a confused chronicle of Kings and constitutions, all living without electricity or gas or penicillin, infinitely remote and really very boring. Both the discipline and the charm of historical studies disappear altogether under this treatment. Attempts are made to justify it by the plea that the more history a child knows when he leaves school the better, since he will never read it again. Surely, it is wiser to admit quite frankly that in the time available a scientist cannot learn much history at school and to try and persuade him to enjoy what he does do, so that he will want to read it for himself after leaving school."

The writer of the editorial in the Connecticut Journal concluded, and we think most appropriately:

"General education in an age of science means education in the ends of human endeavor as well as in the means, education in the promptings for good and for evil of the human heart as well as in the skill of human hands."

IDEAL DOCTOR*

(A Patient's-eye View)

What makes an "ideal doctor"? Many folks speak nostalgically of the "old family doctor"—the combination physician, father-confessor and friend. Few people would entrust their care to him today, for often he had more sympathy than skill to offer. It is from

fond memories of the horse-and-buggy doctor, however, that people draw their conception of the ideal doctor.

To the patient, a good physician is "gentle, kind, even-tempered, always available, tireless, inexhaustibly patient, everlastingly resourceful, and, up to this morning's radio broadcast, completely informed."

A good doctor-patient relationship, often termed "the most important factor in the practice of medicine," depends upon not only giving people the best possible medical service, but in maintaining their confidence and friendship. Too often patients complain that "doctors are cold and impersonal." How do you win the affection and friendship of the patient? Through frank and friendly attention, relief of pain and ease of mind, but above all, by treating patients as people.

Patients want to feel they are important to the doctor as people—not just as clinical cases. Says one physician: "Be glad to see patients, even if you are a little tired; be frank, be prompt, never give the impression you are doing the patient a favor." Skill is no substitute for kindness.

Cold, calculating science can never replace the warmth of a sympathetic personality. Healing the body is not enough. If a physician is to fully meet his medical responsibilities, he must comfort the soul, too. This is no task for the psychiatrist alone. It is the plain duty of every practicing MD.

*Reprinted from: Public Relations Manual—AMA.

ESTES SURGICAL SUPPLY COMPANY

Phone Walnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

Stone Mountain Sanitarium operating as STONE MOUNTAIN MANOR STONE MOUNTAIN, GEORGIA (Suburban Atlanta)

For the treatment of Psychiatric illness and addictions. Analytically oriented Psychotherapy — Recreational Therapy — Electric Shock. Custodial care for seniles.

Phone—Stone Mountain 2511
Atlanta Office—803 Medical Arts Building
(Phone—ALpine 5848)

W. E. Burdine, M. D. — Medical Director
Vernelle Fox, M. D. — Chief of Geriatric Service
Roy M. Mundorff — Administrator

The Journal

of the

South Carolina Medical Association

VOLUME L

March, 1954

NUMBER 3

*Resistant Rickets**

JOHN R. PAUL, JR., M. D.

Charleston, S. C.

Resistant rickets is a metabolic disease which is present from birth, though it is not usually apparent until the second year of life. It is active throughout the formative years and may persist into adult life as osteomalacia. It is practically identical with ordinary rickets from the pathologic, radiographic and bio-chemical standpoints, the chief difference being one of degree.

The disease is not due to any primary fault of the absorption of vitamins, but rather to a specific resistance of the end organs to ordinary or "large" doses of vitamin D, and its requirement of massive doses of the vitamin for the maintenance of proper blood calcium and phosphorus levels, and therefore, the proper laying down and growth of bone.

We neither understand the action of vitamin D as a regulator of calcium and phosphorus metabolism in the normal individual, nor do we understand why the patient with resistant rickets requires more of the vitamin. Certainly there is nothing wrong with the ability of the body to synthesize bone, if a proper medium is supplied to the growing tissues.

Experimental work has demonstrated three actions of vitamin D. First, the child with untreated rickets, and also the child with resistant rickets, loses calcium in large quantities in the feces. Practically no calcium is excreted by the kidney, even though the serum calcium be within normal limits. Therefore, vitamin D has a specific action on the gut which promotes absorption of calcium, or prevents excretion through its walls.

Second, Harrison and Harrison have proved

that the vitamin specifically increases the renal threshold for phosphorus, irrespective of calcium levels. This is a tubular reabsorption mechanism.

Third, Smith, Freeman and Dunskey have shown that excessive doses of vitamin D, even in the presence of prolonged experimental calcium starvation, causes hypercalcemia by removing calcium from bone. This action proceeds to renal and tissue calcinosis even in the face of the development of severe osteomalacia, and is irrespective of parathyroid pathology.

Thus, vitamin D controls calcium and phosphorus metabolism. Inadequate amounts cause failure of absorption, or excessive fecal loss of calcium (and also urinary loss of phosphorus), while excessive doses lead to toxic hypercalcemia and calcinosis, even to production of severe rickets and osteomalacia, if calcium is low in the diet.

In the patient with resistant rickets, there seems to be simply a requirement for extremely large doses of vitamin D in order to govern the homeostasis in respect to calcium and phosphorus. There is one difference that has been reported in many cases between resistant rickets and ordinary rickets. Whereas the treatment of ordinary rickets leads to establishment of normal serum phosphorus, the patient with resistant rickets for some reason usually has a persistently low serum phosphorus, even though the alkaline phosphatase is reduced to normal, indicating arrest of the activity of the rachitic process.

In December of 1934, Dr. D. V. McCune¹ reported a case of refractory rickets to a regional meeting of the American Academy of

* Read at the Annual Meeting of the South Carolina Pediatric Society, Sept. 15, 1953.

Pediatrics. He stated that this disease had been well known for several years, and that other cases had been reported by Park, Blackfan and Freudenburg. However, his case is the first that has been reported that responded by healing under the influence of massive doses of viosterol.

Fourteen years later, Dr. McCune² reported to the Society for Pediatric Research, that there had been reported in the world's medical literature, only thirty cases of this syndrome. Of these, ten cases came from his own clinic at Babies Hospital in New York.

Since that time there have been a few other reports of series of cases from large institutions. Holt reviewed the literature and presented seven of his own cases in 1951.³

The features of the disease are those of florid rickets developing in a child despite adequate diet and supplemental vitamins. The clinical signs usually become evident about the end of the first year, and the true diagnosis is rarely suspected before the age of two. Usually the child will walk at a normal age, and dentition will begin at the usual time. However, some months after the child begins to walk, deformities become obvious and may often cause such pain that the child will stop walking.

Several writers have reported more than one case in a family, either in siblings or in the family tree. Therefore, there is undoubtedly a hereditary factor, though this must be a recessive trait.

The differential diagnosis includes other conditions which cause similar deformities. These are renal rickets or hyperparathyroidism, true idiopathic hyperparathyroidism, the osteochondrodystrophies, chiefly Morquio's disease, the steatorrheas, and the Fanconi syndrome. Holt has pointed out several cases of refractory rickets that were formerly classed as Morquio's disease, even though the diagnosis of rickets was first made on chemical and roentgenologic grounds, only to be changed to chondrodystrophy when ordinary doses or even several times ordinary doses of vitamin D failed to effect a cure.

In refractory rickets, the diagnostic findings are: A normal or slightly low serum calcium, a low serum phosphorus, and a markedly increased alkaline phosphatase; in other words,

the findings are those of typical active rickets. Kidney function is in all respects normal, glycosuria is absent, though some studies have shown that there may be a transient or relative lowered renal threshold for sugar. The Sulzberg test for calcium in the urine is negative. These findings, with typical clinical and x-ray findings and their persistence after a reasonable trial with generous doses of vitamin D make the diagnosis.

It is interesting that every writer who has reported cases of this disease has cited case after case in which orthopedic measures have been instituted, which have either had transient or negative value, or have actually increased the difficulty of the patient. This statement is not intended to reflect in any way on the orthopedic surgeons, because in most cases the orthopedists were only called in after medical men in charge had been unable to make the correct diagnosis or give treatment of value. Most of these cases had osteotomies, which usually healed well even without adequate treatment with massive doses of vitamin D. However, the deformities usually recurred within one or two years, and the end result has usually been one of angular deformities at or near the operative site.

Treatment of the disease must be individualized as the severity of the condition seems to vary considerably. The drug to be used must be a pure vitamin D and not an A & D combination or some other multi-vitamin product. Either vitamin D₂ or D₃ may be used. Undoubtedly, it is perfectly safe to use tremendous doses from the start, if one is absolutely sure of the diagnosis. Perhaps it is safer to start with some such dose as 50,000 to 100,000 units once a week, for the first two or three weeks, then increase to 500,000 or 1,000,000 units as often as once a day. The dose which causes retention of calcium as judged by x-rays and clinical progress, may be continued until tissue saturation occurs. This point may be determined very simply and safely by daily test of the urine by the Sulzberg reagent. This reagent can be compounded by any pharmacist.

A positive test is obtained in the normal person after ingestion of 1 or 2 glasses of milk. The small traces of calcium normally present

in the urine after fasting do not precipitate qualitatively. Therefore, this very simple qualitative test is actually made to order, and is a very sensitive test for sub-normal, normal, and abnormal urine calcium, particularly for a growing child.

It is customary to take blood for determination of calcium, phosphorus and alkaline phosphatase fairly frequently during the course of treatment. However, these values will not vary significantly until just before the point of skeletal (and tissue) saturation with calcium is reached. As soon as this occurs, the kidney will begin to spill excess calcium. There will then be a reasonable lag before the serum calcium actually begins to build up to toxic levels.

Thus, when calcium shows up qualitatively in the morning urine, the dose of vitamin D is immediately cut off. The treatment then enters the phase of determining the maintenance dose. Here again, there is marked individual variation. And here again, the daily qualitative test of the urine is an essential guide.

Ordinarily the maintenance dose in the reported cases varies from 50,000 to 100,000 units daily. However, there is also marked variation in vitamin D requirements of particular patients from time to time. Holt stresses the fact that the chief danger to these patients, is immobilization, as for orthopedic surgery. It is probably wise if such procedures are contemplated to omit the vitamin D for one to three weeks before casts are applied. If this is not done, severe hyperealeemia may occur during immobilization with resultant kidney damage that may not be reversible.

CASE REPORT

S. K., a male infant was born on June 24, 1950, to healthy parents who have one older healthy son.

His birth weight was seven pounds, eight ounces. There were no neonatal difficulties. He had gained only four ounces above his birth weight at three weeks of age when he came for his first office visit. For the next three months, despite a tendency to loose stools, he had an average gain of three pounds a month. Thus, at four months of age he weighed sixteen pounds, five ounces, and at five months he weighed seventeen pounds, four ounces. The family moved to Orangeburg when he was five months old and the child's supervision was

continued by a practitioner there. He was brought back to my office at eleven months of age. In the preceding five months he had gained only two and one-half pounds.

The child was never breast fed. A modified evaporated milk formula containing 400 units of vitamin D to the can of milk was used throughout the first year. In addition, the child was started on oleum percomorphum, ten drops a day, at his first office visit at three weeks of age. Orange juice was also started at this time and he has always taken this very well (three to four ounces a day).

He developed a cold at four months, which persisted more or less constantly until he was two years of age. After about six months of age he became sickly, had a poor appetite, frequent upper respiratory infections, often complicated by otitis media, and almost constant diarrhea, particularly if coarse foods were taken.

At eleven months the patient was noted to have a moderate rosary, epiphysitis and cranio-tabes. At this time these findings were not too surprising, in the light of the very bad winter of colds and anorrexia. It was also thought then, that there might be a slight fat intolerance because of the history of recurrent, though not severe, diarrhea. Oleum perco-



Figure 1. Both forearms on May 19, 1952, at the time of diagnosis of resistant rickets, and beginning massive therapy.



Figure 2. Patient at time of beginning massive therapy.

morphism was discontinued and a large dose of ABDEC (1.2 cc) was prescribed. It was also suggested that additional sunshine would be of value.

The child did not come back to me until May of 1952, exactly one year after the previous visit. During the second year his mother, who is very conscientious and cooperative, had not missed a day giving two droppersfull of the multivitamins. In October 1951 she consulted another doctor in Orangeburg, who also noted the rickets. This doctor prescribed ten drops a day of "super D". The mother gave the "super" vitamin D in addition to the ABDEC, from October 1951 to May 1952. The child had started walking at about one year of age. However, in October 1951, when he was seen by the doctor in Orangeburg, he was beginning to limp. Therefore, consultation with one of the state's leading orthopedists was advised. Orthopedic shoes were prescribed by this doctor, whereupon the patient stopped walking altogether.

On examination at two years of age the

child weighed twenty pounds, thirteen ounces, a gain of exactly one pound in the previous year. At this time the child had obvious, severe rachitic deformities of the head, chest, spine and extremities. He had only eight teeth. The fontanelle was wide open and persistent craniotabes was present. Examination was otherwise not remarkable.

The hemoglobin was 13.8 grams (80%). Urine had a specific gravity of 1.028, was acid, clear and negative for sugar, albumin and calcium (Sulkowicz test) and microscopically. Blood was reported as follows: calcium 8.2, phosphorus 2.8, alkaline phosphatase 6.9 units. X-rays of the long bones showed far advanced rickets with pathological fractures of both ulnae. The bone age was approximately six months.

In spite of the low alkaline phosphatase, which I cannot yet explain, the diagnosis of resistant rickets was made, and the child was started on Infron, 100,000 units orally every three days. Three weeks later the mother stated that his appetite and disposition had greatly improved and that his bowels were normal. He has had no diarrhea since that time. The routine urinalysis was again nega-



Figure 3. Anterior-posterior and lateral views of left forearm on May 20, 1953. Reported to show complete healing of rachitic process—minimal residual deformities.

tive, and calcium was absent. Infron was continued, and he was started on 500,000 units of Ertron once a week by intramuscular injection. The mother was given an eight ounce bottle of Sulkowitz reagent, and she has tested his urine for calcium at least once daily since that time.

On June 10th, the Ertron was increased to 1,000,000 units weekly by injection only. On June 24th, the dose was doubled to 1,000,000 units twice a week. On July 8th the mother stated that he was beginning to stand alone, and examination revealed two pre-molars through and the other two coming. On July 22nd, x-rays were repeated and reported to show little, if any, change. Ertron was increased to 1,000,000 units three times a week. On September 3, 1952, the radiologist gave the first encouraging report of definite narrowing of epiphyseal plates. There was still gross cupping. Blood showed calcium 9.0, phosphorus 2.7, alkaline phosphatase 19.8. From October 1952 to January 1953, injections of Ertron were



Figure 4. Photograph of patient in May, 1953.

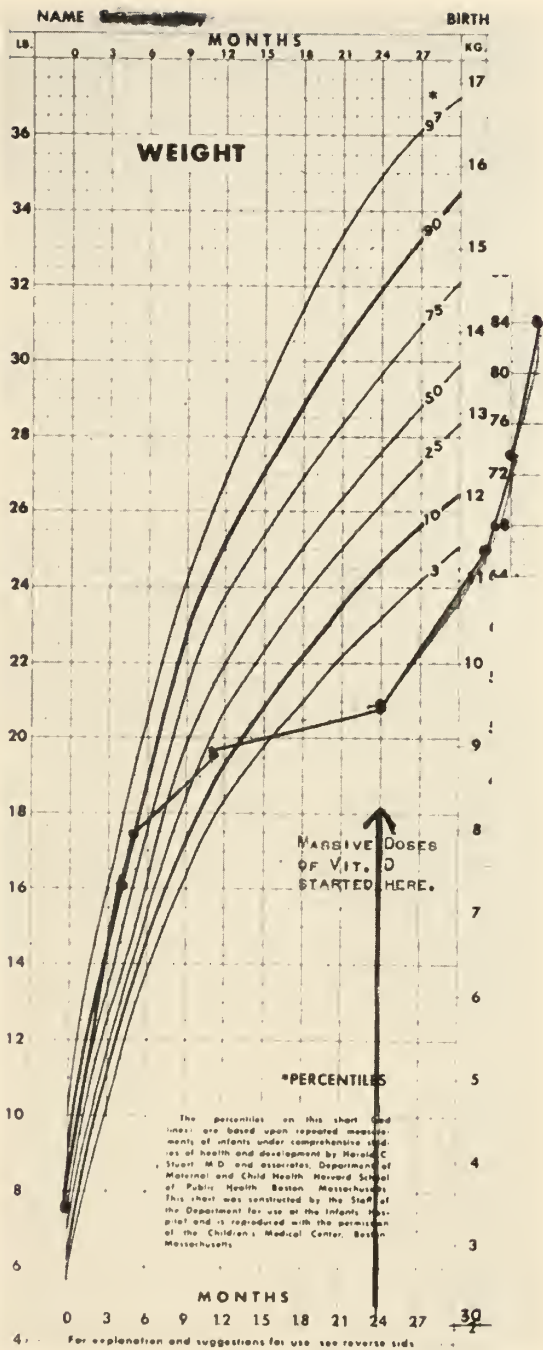


Figure 5. The patient's weights as recorded on a Whetzel grid, showing better than average weight gain for first five months, almost complete arrest for next 17 months, and then return to previously established channel one year after beginning massive vitamin D therapy.

missed occasionally, but the child usually got from one to three million units per week. By January 1953, he was walking very well (with shoes that have internal wedges). He weighed

twenty four and one-half pounds, and had sixteen teeth. Fontanelle had closed. Blood chemistry remained essentially unchanged: calcium 9.2, phosphorus 4.5, alkaline phosphatase 19.2 units. X-rays showed continuing improvement. On that day he was started on an oral preparation of irradiated ergosterol of extremely high potency* He could not swallow capsules. This preparation contains approximately 50,000 units of vitamin D per drop. Because we were not sure of the standardization of the Ertron, it was thought best to reduce the unit dosages, and he was started on three drops per day. Two months later the dose was increased to four drops or 200,000 units daily.

On March 26, 1953, ten months after beginning massive therapy, calcium first showed up in the urine. The mother stopped giving vitamin D, and the Sulkowicz test showed one to two plus for two weeks before becoming negative again. Two drops a day were then given for three weeks, before calcium showed positive again. Vitamin D was again stopped and the urine cleared in one week. On May 20, 1953, at three years of age, one year after beginning treatment, the child weighed twenty seven and one-half pounds. He is now bright

* This material was supplied to me by Dr. Douglas Remsen of the E. R. Squibb Company, so that we could treat this child without the frequent painful injections.

You are to know that there are two broad motives for a man's following medicine: either he loves his kind, and wishes to serve them; or he loves science, and would fain pursue it. There are no other motives which can lead one to distinction among us. You see that in a fashion a doctor must be something of a missionary, something of an idealist, and very much of an enthusiast. He must have breadth of vision, sanity; a mind capable of work without flagging; readiness to accept the new, courage to reject the old; optimism, and a scorn of that crabbed skepticism which glories in entrenched dogma. DOGMA has no place in the vocabulary of science; nor has HERESY. Remember that Voltaire defined a heretic as a man who does not believe as I do. Above all, a doctor must have sound health—during his early years, at least.

James G. Mumford
"A Doctor's Table Talk" 1912

and cooperative. He is said to run all day in "socket-fit" shoes. His appetite is fair. He threw off the few colds he had last winter without difficulty. The blood calcium was 9.6 phosphorus 5.2, and alkaline phosphatase 6.0 units. The radiologists report was "healed rickets with moderate deformities of the long bones."

SUMMARY

The subject of resistant rickets is presented and defined. A typical case, treated entirely as an office patient, is presented.

The paper was discussed by Dr. Gilbert Forbes, Clinical Associate in Pediatrics, University of Rochester School of Medicine, Rochester, New York. Dr. Forbes stressed the fact that atypical rickets is being seen more frequently every year because ordinary rickets has been practically eliminated by universal use of vitamin D, and the less common forms are seeking clinic-evaluation and being referred. He mentioned that there is one other disease that has recently been described and reported, namely a form of resistant rickets associated with an apparently familial, congenital deficiency of alkaline phosphatase.

REFERENCES

1. McCune, D. J., Refractory Rickets, J. Pediat. 6:872, 1935.
2. McCune, D. J., Refractory Rickets, Am. J. Dis. Ch., 77:112, 1949.
3. Holt, J. F., Vitamin D Resistant Rickets (Refractory Rickets), Am. Jour. Roentgenol., 64:590, 1950.

The comparing of experiences, and the balancing of promise against accomplishment, is one of the pleasures of maturity, and sometimes one of its pains. Out of the twenty-four men from my college class, who "went into" medicine, eighteen still write themselves "Doctor." That does not mean that a quarter of our number have forsaken medicine for other callings. Those six men, no longer in our ranks, are either dead or they never matriculated at a medical school. Here is an interesting fact about physicians, a fact unique,—they rarely change their job. You don't hear it said of a man active in the world that he *used to be* a doctor. Physicians sometimes retire, but not for change of business. This is true of no other class of men. Medicine gets a grip which is seldom loosened. It has a fascination all its own. There is a peculiar freemasonry, as there is a peculiar code of ethics, among doctors.

James G. Mumford
"A Doctor's Table Talk" 1912

Glaucoma and the General Practitioner

L. D. LIDE, JR., M. D.

FLORENCE, S. C.

Glaucoma is one of the most common causes of blindness in this country today. It is estimated that 800,000 people have it and that 2 out of every 100 adults over the age of 40 are affected by it. Frequently, it is only after the disease is far advanced and much irreparable destruction of vision has occurred that the patient is seen by the ophthalmologist. Since most of the loss of vision due to glaucoma is permanent, the prognosis is far more favorable if the disease is discovered early. If we are to prevent this blindness, early discovery and institution of treatment and indefinite maintenance of adequate treatment are essential. As in many other diseases, the general practitioner can play a vital role since he is frequently the man who sees the patient first. When the physician develops a high level of suspicion of glaucoma in his patients, more of them will be seen early enough to prevent much of the damage of the disease.

Glaucoma is not a single disease entity. It is present in any eye in which the pressure is too high for that eye. The underlying pathology may be quite varied. Actually the glaucomas are a group of diseases which have in common the outstanding feature of elevated intra-ocular pressure. Fortunately, glaucoma is not very common in children and young people, although it occurs at any age. The older the patient, the more likely he is to have glaucoma. It is relatively rare before the age of thirty-five. It is rather common in Negroes and also rather resistant to treatment in this race.

Glaucoma may be primary or secondary. This discussion will be confined to the much more common primary glaucoma. Primary glaucoma can be divided into acute and chronic types. The chronic can be further subdivided into chronic congestive and chronic simple. A little discussion of the physio-pathology of the disease can be helpful in our understanding of the problems presented. Whenever the pressure in an eye is too high, that pressure is exerted in all directions. Some of

the ocular structures are, however, much more susceptible to pressure than others. The loss of vision is due, primarily, to damage from pressure upon the optic nerve and retina. There are two pressure effects. First, that of sudden, acute, severe elevation of pressure, such as is seen in acute congestive glaucoma. This does serious damage in a very short while. Here, the visual loss is due to damage to the retina, probably directly from pressure on the rods and cones or the nerve fibers of the retina, or possibly, indirectly from vascular changes. If this pressure is not relieved in a short time, severe and permanent visual loss can occur. On the other hand, if this pressure is relieved early, there may be a return of vision to normal levels. The second effect of elevated intra-ocular pressure is that of moderately elevated pressure exerted upon the ocular structures over a long period of time. The lamina cribrosa of the optic nerve is the weakest portion of the coats of the eyeball. This gives way first. Excavation or cupping of the optic nervehead occurs. The nerve fibers are stretched over the sharp margin of the scleral ring. Interference with function and subsequent atrophy occur. Once this damage has been done, most of it is permanent.

The aqueous is produced at a fairly steady rate within the eye by the ciliary processes of the ciliary body. It then finds its way forward through the pupillary space into the anterior chamber. It must flow from the anterior chamber by way of the canal of Schlemm. Guarding the canal of Schlemm is the trabeculum. In the trabeculum there are multiple microscopic spaces through which the aqueous must pass. The drainage angle, at the apex of the angle formed by the iris and the peripheral cornea, is normally hidden from view as one looks at the eye. Some eyes have a shallow anterior chamber where the space between the posterior surface of the cornea and the anterior surface of the iris and lens is rather small and where the angle is narrower or more acute than normal. If the root of the iris should

come in contact with the posterior surface of the cornea, then the trabeculum would be closed off and the out-flow of fluid would be very effectively blocked. Such an eye then has a predisposition to narrow-angle glaucoma. Pressure from behind, forcing the iris forward, or dilatation of the pupil might place the iris in contact with the trabeculum. This is the mechanism in narrow angle glaucoma of which acute congestive glaucoma and chronic congestive glaucoma are examples. Since the entire circumference of the drainage angle may be closed at one time, the pressure may go rapidly to very high levels producing acute congestive glaucoma. If only a portion of the angle is closed off, chronic congestive glaucoma may result. On the other hand, if the anterior chamber is of normal depth and if the drainage angle is wide, an eye may still have glaucoma from obstruction to out-flow due to pathology of the trabeculum or other portions of the drainage apparatus. Among the possible causative factors are sclerosis of the trabeculum, narrowing of the lumen of the aqueous veins, or blocking of the trabecular spaces by pigmentary or cellular debris. If any of these conditions should occur, the out-flow of fluid from the eye would be obstructed and chronic simple glaucoma would be the result.

SIGNS AND SYMPTOMS OF ACUTE CONGESTIVE GLAUCOMA:

The onset is usually quite sudden and may occur in the middle of the night. The condition may be bilateral. The pain in the eye is usually severe, and radiates to involve the whole side of the head. It is a deep pain. The loss of vision is usually severe. This combination of pain and loss of vision is, in the large majority of cases, due to acute glaucoma. Wherever the two occur together, it must be ruled out. As a result of vascular decompensation, the eye is acutely congested and red. The cornea is steamy. The patient may see haloes around lights. It is usually impossible to get a view of the ocular fundus because of the corneal changes. The pupil is moderately dilated and usually irregular in outline. The anterior chamber is shallow. There may be excessive lacrimation and some edema of the lids. The tension is usually very high, between 60 and 100 mm. of mercury. On palpation, the

eye feels hard. Nausea and vomiting are frequently present, the result of a reflex by way of the vagus nerve. Oftimes much valuable time is lost while the patient is being treated for a gastro-intestinal condition, when in reality he has glaucoma. Acute congestive glaucoma is an emergency. Every hour of delay in institution of treatment may mean permanent visual loss. Delay of treatment beyond 48 hours may result in total permanent blindness of that eye.

Differential diagnosis of acute congestive glaucoma from acute iritis and from acute conjunctivitis is not always easy. In acute iritis the pupil is usually small and immobile. There is deep circumcorneal congestion. The pain may be severe. The ocular tension is usually normal or subnormal, but it may be elevated, giving the patient a glaucoma secondary to iritis. If a case of glaucoma is confused with iritis and placed on atropine, which is usually used in acute iritis, one can readily see how disastrous the result would be. It is well to point out at this time some of the potential dangers of the use of atropine. The older elementary text-books recommended its use in almost every condition except glaucoma. Later knowledge has shown that this is frequently unwise. The use of atropine in any patient over the age of forty should be undertaken very cautiously. It is not well to use it routinely after the removal of corneal foreign bodies. It has very little place in the treatment of conjunctivitis, even of moderate severity. Actually, there may have been cases where acute congestive glaucoma was brought on by the use of atropine and its derivatives systemically. Since the differential diagnosis between acute glaucoma and acute iritis is frequently quite difficult, treatment of iritis should not be undertaken without careful study and cautious use of drugs. Acute conjunctivitis usually is marked by a more superficial conjunctival congestion. The pupil is mobile, equal, regular and reacts to light. The vision is not usually affected to an appreciable degree nor is the pain deep and severe. One can get a good view of the ocular fundus. In acute conjunctivitis the secretion is usually purulent. If there is any doubt about whether a case is one of conjunctivitis or of glaucoma, don't lose valuable

time on a therapeutic test of antibiotics.

The treatment of acute congestive glaucoma consists first, of intensive miotic therapy. Four percent solution of pilocarpine, 5% solution of prostigmin bromide, 1% solution of physostigmine, or other similar drugs instilled into the eye every 15 minutes for 2 hours, with subsequent decrease in frequency of administration to every 30 minutes may result in a lowering of the tension. If the tension is adequately lowered, no immediate surgery is necessary. Usually within 4 to 8 hours, one can tell what the result of the miotic therapy is going to be. The level of the patient's vision is important in the decision on how long miotics may be tried. If the vision is down to hand movements, delay cannot be tolerated. The patient may experience considerable pain from intensive miotic therapy, but this is not to be confused with that of glaucoma. In a patient with acute congestive glaucoma, if the tension is not relieved, surgery should be done. If the case is only 48 to 72 hours old, or if the tension comes down to normal on miotics, an iridectomy should be done as the operation of choice. A peripheral iridectomy is usually quite adequate. If, on the other hand, the condition has existed longer, one of the filtering operations may be necessary. Or, as Chandler¹ has recommended, one may do an iridectomy and open the angle with a cyclodialysis spatula. In a narrow angle glaucoma, if iris is removed from a peripheral portion of the angle, aqueous can reach the trabeculum and the obstruction may be relieved. As a general rule, any patient who has had acute congestive glaucoma and had the tension relieved by miotic therapy, should not be allowed to leave the hospital before an iridectomy can be done. Once he has had an attack, it is fairly certain that he will have another sooner or later. An iridectomy may prevent it entirely. It is preferable to operate on an eye in which the tension has been lowered and the vascular congestion has subsided. The operative results are better than if the operation has to be done while the tension is elevated.

CHRONIC GLAUCOMA

In contrast to the dramatic, sudden onset with severe pain, marked loss of vision, and redness of the eye of acute congestive glau-

coma, there is a marked lack of symptoms in the early stages of chronic glaucoma. Chronic glaucoma may be of the chronic congestive or chronic simple type. The former may be the end result of mild and self-limited attacks of acute congestive glaucoma. It may result whenever the drainage angle is narrow and the drainage outflow is partially obstructed by adhesions between the iris and the trabeculum or the posterior surface of the cornea, adhesions known as peripheral anterior synechiae. The obstruction to outflow may be partial but constant. On the other hand, chronic simple glaucoma has an angle which is wide and the elevated pressure is due to obstruction in the drainage channels. Long continued elevation of intra-ocular tension results in cupping and atrophy of the fibers in the nerve-head. The cupping is usually proportional to the loss of field. In other words, one can predict roughly which portion of the visual fields will show constriction. The field changes of glaucoma usually follow certain characteristic patterns, as some nerve fibers are more susceptible to pressure damage than others. Chronic glaucoma is an insidious disease. Oftentime, the patient does not know he has it. Chronic glaucoma is far more prevalent than acute congestive glaucoma. The prognosis in chronic glaucoma is so much better in cases that are discovered early. In those cases in which the pathologic process is already advanced, the treatment, both medical and surgical is nothing like as effective. Even in spite of apparently adequate lowering of the tension, further loss of vision may occur. It is as if the pathologic process, once instituted, progresses in spite of treatment. It is well to remember also, that some cases of chronic glaucoma, since it is a degenerative disease, will progress in spite of all therapy.

SIGNS AND SYMPTOMS:

Besides elevated tension, which is as a rule, mildly or moderately elevated to perhaps 35 m.m. the first sign is usually loss of peripheral vision. At first this can only be picked up by detailed visual field studies. Central visual acuity is usually not affected at first. Cupping of the optic nerve occurs later. Subjective loss of peripheral vision and ophthalmoscopic evidence of cupping of the nerve-heads are

late signs. As the disease progresses, the peripheral fields may be lost to the point where the patient may have only gun-barrel vision. In time, even this island of sight may be lost. Occasionally one sees a patient with reasonably good visual acuity and yet because of the loss of visual fields, he is industrially blind. He can't see to get about without stumbling over everything. Once this loss of field of vision has occurred, it is for all practical purposes permanent. Usually these patients have such a mild elevation of tension that it can not be picked up on palpation by the average physician. Taking the tension with the tonometer is essential. Confrontation fields are totally unreliable because, for this test to be positive, the loss of field has to be profound. It may be well to mention here, that tactile tension, while extremely useful and important has to be checked frequently by the tonometer. The average ophthalmologist takes tactile tension on practically every patient he sees. If there is the slightest doubt in his mind about the tension of the eye being near borderline, it must be checked by the tonometer. It is amazing how widely ones fingers can vary in their interpretation of the tension within an eye. If the tactile impression is not frequently checked by the tonometer, it can get far away from the actual levels.

TREATMENT:

The treatment of chronic glaucoma consists, first of all, in advising the patient of the presence of the disease and of the necessity for treatment and of the prognosis. A trial of miotic therapy comes first. It may be necessary at first to see the patient every few days for a number of weeks. The desired result is to find the miotic of the lowest strength which will maintain the patient's tension at normal levels. This may vary considerably in different patients. A miotic which at first will be effective may later be ineffective. Increase in the concentration of the drug or change to another may be necessary. Frequent field studies are essential. At first we need to get a clear picture of the visual field loss and more than one charting is necessary to establish this. Subsequent field studies are necessary to detect any further loss of visual field, because continued loss of field is a strong indication for surgical inter-

vention. Decision as to whether surgery will be necessary depends primarily upon the state of the ocular tension, the state of the visual field and any progressive loss, and the age of the patient. Surgical treatment may take one of several forms of filtering operations. In chronic glaucoma, an iris inclusion operation may be done in which a wick of iris is pulled out into the corneoscleral incision, thus permitting aqueous to drain into the sub-conjunctival space for subsequent absorption. Or, one may do a cyclodialysis in which a cleft is made between the ciliary body and the sclera, thus allowing the aqueous to drain into the suprachoroidal space and there be absorbed by the abundant vascular channels in this area. On the other hand, a different approach to the problem may be necessary, if efforts to increase the drainage from the eye are not adequate. One may take steps to decrease the production of aqueous within the eye. This is done by electro-diathermy coagulation of the ciliary body. Subsequently, atrophy of portions of the ciliary processes result and there is a decrease in the production of aqueous. This operation may become necessary, particularly in the more advanced cases.

Glaucoma operations may have to be repeated or new ones done to bring the disease under control. If the intra-ocular pressure remains too high, loss of sight is bound to result. In doing glaucoma surgery, one has to proceed cautiously so that enough will be done without too much being done. It is well to mention here that it takes a great deal of courage to do glaucoma surgery. With the realization of the inevitable loss of vision and ultimate blindness which faces the patient, the ophthalmologist may have to advise surgery at a time when the patient's vision has not yet been seriously affected.

The general practitioner can be of great assistance to the ophthalmologist in affirming to his patient the necessity for his use of miotics. Instillation of drops in the eye has to become a very regular habit with the patient. Use of these drugs day in and day out is necessary, as a rule, for the balance of the patient's natural life, or until surgical intervention becomes necessary. The family physician can also help a great deal in advising his patient

about surgery and the necessity at times for repeated surgery.

PROGNOSIS:

As to prognosis, the most favorable cases are those found in the course of routine eye examination. Usually the patient comes in merely asking for a change in glasses. On examination the pressure is found elevated. Visual field changes are minimal, if present. This is one strong reason for advising the patient over forty to have a thorough eye examination at least every two years and in some cases every year, whether he has any symptoms or not. Far too many patients with chronic glaucoma do not reach the ophthalmologist until the vision of one eye is totally gone and that of the other very seriously impaired. These are the tragedies. Occasionally, one sees a patient who is blind in both eyes, and who was thinking that he probably had cataract which could be cured by surgery whenever he got up courage enough to have it done. Many laymen have the idea that all serious visual losses are due to cataract and can be corrected with surgery. They don't realize that the loss of vision due to glaucoma is irreparable. It is disturbing to see such tragic cases in which the patient is partially blind, when the condition could probably have been prevented. Often the patient will tell you that he has had his glasses changed in the past year or two by a non-medical refractionist. The use of a tonometer is essential to diagnose early chronic glaucoma. Any patient, particularly those in the forty-or-over age group, who complains of seeing haloes around lights, intermittent blurring of vision, failing vision, loss of peripheral field and any other vague complaints about his seeing, should have a comprehensive eye examination to rule out glau-

coma.

Still another type of primary glaucoma is congenital glaucoma. In many cases the underlying pathology in congenital glaucoma is a failure of the mesodermal tissue, normally in the drainage angle, to absorb before birth. There results an obstruction to the outflow of fluid from the eye. Increased intra-ocular pressure is the result. In the infant or young child, the coats of the eye are relatively elastic. There may be stretching of the globe from elevation of pressure over a period of time. Stretching of the cornea may result in much enlargement of the cornea, increasing its curvature, and causing breaks in Descemet's membrane which lead to scarring and subsequent disturbance of vision. If the condition exists longer, the whole eyeball may become very much stretched and enlarged, resulting in buphthalmos or so-called "ox eye." Of course, cupping of the optic nerve likewise occurs. Congenital glaucoma requires early treatment. The treatment is at best, very difficult and often unsuccessful. At present, goniotomy, which is an operation that consists of going in with a special knife and cutting some of the mesodermal tissue left in the angle, seems to be the operation that gives the most favorable results. The family physician may discover these cases of congenital glaucoma because of steaminess of the cornea or enlargement of the eye, or poor vision.

To summarize: Glaucoma is a serious cause of blindness. It is usually insidious and the damage done is permanent. Early institution of treatment can prevent much of this tragic blindness.

REFERENCE

1. Chandler, P. A., Arch. Ophth. 47: June 1952. 695.

Gonococcal Urethritis with Bacteremia

REPORT OF A CASE

ROY A. HOWELL, JR., M. D., STACY H. STORY, M. D. AND REBBIE HOLT, B. S.*

Acute gonococcal urethritis is usually unaccompanied by generalized symptoms.¹ That the gonococcus does at times enter the blood stream is evident from the frequency of arthritis, meningitis and endocarditis. However, the organism does not thrive in the blood, as attested to by the infrequency of gonococcal septicemia. Especially since the advent of penicillin has gonococcal septicemia become a rarity and reports of this disease have in recent years been very few.^{2,3} Most of the reported cases of gonococcal septicemia occurred before the use of the sulfonamides and penicillin and were characterized by a relatively prolonged course of fever, joint manifestations and skin rashes, not unlike meningococcemia.⁴ The death rate was high, but recovery was not unusual, in contrast to the cases with endocarditis.

We wish to report an unusual case of gonococcal urethritis accompanied by bacteremia and certain of the signs and symptoms of a septicemia.

Report of a Case

F. W., a twenty three year old negro male laborer, was admitted to the medical service of Roper Hospital on August 8, 1952, with the chief complaints of fever and weakness of seven hours' duration. The patient had been in good health until the morning of admission when he noted marked malaise and weakness, anorexia, nausea and headache. He developed high fever accompanied by chilly sensations and pain in both legs. He remained in bed all morning and, on getting up to get a glass of water, fainted, remaining unconscious for several minutes. Upon awakening, he was taken to the hospital.

The patient had noted some dysuria and double voiding for several days prior to admission but he denied ever having had a urethral discharge. He had had intercourse several times during the previous month, but was reluctant to give details. Three weeks prior to

the onset of his present difficulty he had an episode of fever and headache which subsided promptly after he was given an injection by a local physician. His past history was otherwise non-contributory.

Physical examination revealed a well developed and well nourished young negro male who appeared acutely and severely ill. The temperature was 104° (F.), pulse 108 per minute, respirations 20 per minute and blood pressure 110/70. The skin was dry and very hot; no rash was seen. The pharynx was slightly injected. There was some resistance to flexion of the neck but no definite rigidity. The lungs were clear. The heart was not enlarged, the rhythm was regular and no murmurs were heard. The abdomen was flat, soft and non-tender, and no organs or masses were palpable. There was a profuse, purulent urethral discharge. Rectal examination was negative; the prostate felt normal.

The leucocyte count was 20,800, with 83% polymorphs, 14% lymphocytes and 3% monocytes. The erythrocyte count was 4.3 million and the hemoglobin 13 gm. %. The urine (voided) was cloudy, specific gravity, 1.020; no sugar, albumin or acetone was present; microscopic examination revealed 40 to 50 pus cells per high power field. The blood Wassermann and Kline were negative. The blood urea nitrogen was 16 mg. per 100 cc.

A culture and a Gram stain were made from the urethral discharge and the latter revealed gram negative intracellular diplococci. A blood culture was drawn and the patient was started on intramuscular aqueous penicillin, 300,000 units initially and 100,000 units every three hours. Within 12 hours the temperature had fallen to 100° F. and the patient was feeling much better. By the next day he was afebrile and much improved. He became asymptomatic except for some residual weakness and malaise. The urethral discharge cleared. Penicillin was continued for three days to a total dose of 2.6 million units.

The culture of the urethral pus and the

*From the Departments of Medicine and Bacteriology of the Medical College of South Carolina and Roper Hospital Charleston.

blood culture both grew gram negative diplococci which were identified morphologically, culturally and by fermentation reactions to be *neisseria gonorrhoeae*. The patient remained asymptomatic and was discharged on August 28, 1952.

Comments and Summary

This patient presented the picture of a severe acute infection with marked toxic symptoms. Had it not been for the presence of the urethral discharge, prompt diagnosis would have been difficult. Culture of both the urethral pus and the blood grew out *neisseria gonorrhoeae*. The patient was extremely ill on admission to the hospital but response to penicillin was prompt and dramatic.

Current concepts of treatment of gonorrhea emphasize the "one-shot" method, using 300,000 to 600,000 units of long-acting penicillin, which results in the cure of about 90% of the cases.⁵ It is important to keep in mind, however, that a few cases are not cured with this dosage.⁶ It is also important to remember that blood stream invasion does occur and may give rise to serious complications. For these reasons, all patients with gonorrhea should be questioned and examined carefully before treat-

ment is begun and should return for follow up. In cases with fever or generalized symptoms, larger doses of penicillin than usually employed, preferably in the aqueous form, should be used.

BIBLIOGRAPHY

1. Rolnick, H. C., Practice of Urology, J. B. Lipincott Co., Philadelphia, 1949.
2. Hirsh, H. L. and Kurland, W., Gonococcal septicemia, report of a case, Med. Ann. District of Columbia, 20:81, 1951.
3. Salas, M., et al., Gonococcal septicemia, case in a child, Bol. med. d. hosp. inf., Mexico, 4:619, 1947.
4. Foster, R. C., Gonococcal bacteremia with joint and skin manifestations, Ann. Int. Med., 16:1018, 1942. Ogg, F. W. and Funkhouser, S. P., Gonococcal septicemia with recovery, M. Bull. Vet. Admin., 18:318, 1942. Schneider, J. F. and Massee, J. C., Gonococemia, patient unsuccessfully treated with sulfonilamide, J. M. A., Georgia, 29:276, 1940. Keil, H., A type of gonococcal bacteremia with characteristic skin lesions, Quart. J. Med., 7:1, 1939. Friedberg, C. K., Gonococemia with recovery, A. J. Med. Sci., 188:271, 1934. Filler, W., Gonococemia with recovery, J.A.M.A., 100:1149, 1933. Rubenstone, A. I. and Israel, S., Gonococemia with recovery, J.A.M.A., 96: 1685, 1932. Baker, B. M. and Carter, E. P., Three instances of unusual gonococcal infection, Bull. Johns Hopkins Hosp., 50:57, 1932. Cabot, R. C., An obscure generalized infection, Boston Med. & Surg. J., 197: 1141, 1927.
5. Jones, T. R. L., Donaldson, E. M. and Allen, S. J., One-shot treatment of acute gonorrhea, Lancet, 1:526, 1946.
6. Butter, P. J., Brewer, A. F., Condit, P. K. and Johnston, J., Chloromycetin and penicillin in gonorrheal urethritis, Am. J. Syph., 36:269, 1952.

Pathological Conference, Medical College of South Carolina

Dr. Abram Berry: Mr. Johnson, will you present the protocol on today's conference.

Mr. R. M. Johnson: *PRESENT ILLNESS*: Patient is a newborn colored female who was born spontaneously on June 13, 1952, after gestation of 7 months. The infant did not breathe at first (5-8 minutes), but suction with artificial respiration was applied with good results. Physical Examination: Weight—3 lbs. 2 oz.; fair color and activity; lungs relatively poorly aerated, with rales throughout, and much mucous secretion. Cough reflex active; marked talipes equinovarus of left foot; supernumerary digit present on left hand; heart rate was regular; general condition poor.

HOSPITAL COURSE: The infant was placed immediately in an incubator, was given routine premature therapy, and put on penicillin. June 14: lungs poorly aerated; color satisfactory; temperature ranging in 99s; formula begun. June 15: Left lung shows decreased breath sounds; baby taking small amounts of fluids; clysis given (Hartman's). Temperature here began to assume the spiking character which prevailed during remainder of hospital course. June 17:

Anemia noted; received 30 cc whole blood intravenously, and 100 cc Hartman's by clysis; slight icterus of skin noted before transfusion; lungs slightly better aerated. June 22: Progressive weight loss to 2 lbs. 8½ ozs. noted; polyethylene tube passed for feeding purposes. June 26: Some atelectasis persists; pallor present, given 30 cc blood by intravenous push. June 27: First severe episode of (?) aspiration with cessation of breathing and fairly marked cyanosis following feeding; two milder episodes had been noted by the nurse previously, the first on June 19. Following the episode of June 27, even after caffeine, artificial respiration and O₂, infant had gasping respiration for some time, with suction later productive of large amount of greenish-brown material. The remainder of the infant's course was characterized by intermittent episodes of a similar nature to the above, with gradually increasing frequency and severity; each time there was cyanosis and cessation of respiration, either immediately after feeding or within 15-20 minutes after feeding; each time the infant responded to oxygen, caffeine, and artificial respiration with suction, returning to good color and

respiration within a few minutes. Ordinary vomiting or aspiration did not precede many of these episodes, according to one resident's notes, (although one episode was noted to be preceded by vomiting.) Often there was no coughing; the lungs were noted to be full of rales, with dullness in left lower lobe, at least one time; aeration was noted on both sides, however. Suction obtained mucus or milk each time, apparently from the naso-pharynx; ashen color was often noted upon removal from the isolette.

Anemia was noted several times, and the infant was transfused with 32-40 cc of blood five times. High temperatures were treated with ice bag in isolette and Terramycin was given. Apparently normal yellow stools noted throughout, somewhat less than usual in number. Infant maintained average weight of 2 lbs. 9 ozs. until June 29, then gradually gained to 4 lbs. 5 ozs. at time of demise. On July 28, patient had final episode of cyanosis and cessation of respiration; there was no feeding prior to this episode; apnea did not respond to caffeine this time, neither intramuscular nor intracardiac; artificial respiration failed to give benefit; Cheyne-Stokes respiration had been noted by nurses three hours previously. Heart beat had ceased before resident arrived, and infant could not be revived.

LABORATORY DATA: June 17: RBC 3.98, HGB 11.5

July 8: RBC 2.18; HGB 7.5

July 12: RBC 5.12; HGB 11.5; WBC 10,450; PMN 49; L 43; M 5; E 3

July 18: RBC 4.18; HGB 9.5; WBC 11,050; PMN 65; L 28; M 2; E 5

July 25: RBC 3.00; HGB 9.25; WBC 4,000; PMN 20; L 80.

Dr. Berry: Mr. Stanley, will you discuss this case?

Mr. J. H. Stanley: I think the first thing we have to consider is that this infant did not breathe for 5-8 minutes after birth, but considering the absence of any difficulty for several days after respiration was established and the absence of any neurological signs she must have recovered from this initial insult.

On the 14th we see that the lungs were poorly aerated and on the 15th the left lung showed decreased breath sounds. On this same day her temperature began spiking; so I think we can say she probably aspirated something and had pneumonia. Her temperature continued to spike throughout her life and I believe she had pneumonia all the time in spite of antibiotics.

Then on the 17th, or the 4th day of life, an anemia was noted and 30 cc of whole blood given. At this time a slight icterus of the skin was also noted. Because this occurred on the 4th day of life it appears to be nothing more than physiological icterus of the newborn rather than erythroblastosis fetalis, which should appear earlier, or something like atresia of the bile ducts, which should produce signs later.

Dr. Berry: Wasn't there enough, otherwise, to explain this anemia?

Mr. Stanley: Yes sir, I think just prematurity and in-

ability of the hemopoietic system to respond is the best explanation for it.

Then on the 22nd we see that the infant had had progressive weight loss and a tube was passed for feeding. Then 4 days later the tube was removed; so in this time she must have gained adequate strength and developed a good enough sucking reflex to use a bottle. On the same day pallor was noted and 30 cc more of whole blood was given.

Then on the 27th, or the 14th day of life, she had the first severe episode of aspiration ("questionable") with cessation of breathing and cyanosis—this had been preceded by two milder episodes. With just this one episode I don't think we can say what its cause was, but considering the character of the episodes which followed through the next month until her death several things are suggested.

Diaphragmatic hernia might give this picture. Not absence of one diaphragmatic leaf but one which would develop slowly with a true hernia sac like you might get through the canal of Bochdalek or the foramen of Morgagni. These might develop after several days of handling—with pressure on the abdomen. One thing against this is that no peristaltic waves were heard over the chest and no x-rays were taken which, I am sure, would have been done if this condition had been suggested.

Vascular rings can give episodes of apnea and cyanosis but not like the ones she had.

Mr. Stanley: No sir. These attacks occurred after feeding—usually 15-20 minutes afterwards—and with a vascular ring I would expect the attack of apnea and cyanosis to appear during feeding, even with the first few swallows, because these episodes are supposed to be caused by a bolus of food passing down the esophagus. (Note that attacks frequently were immediately after eating—Ed.)

Then we have to consider tracheo-esophageal fistulas.

Dr. Berry: Is the usual type of tracheo-esophageal fistula compatible with her life span?

Mr. Stanley: No sir, not the most common type, but the most uncommon type is.

Dr. Berry: What is the most common type?

Mr. Stanley: It's the type in which the esophagus ends in a blind pouch. There is also a segment above the stomach which connects with the trachea.

Dr. Berry: Would passing a tube help rule out tracheo-esophageal fistula?

Mr. Stanley: It would help rule out all except the most uncommon type which is the "H" type. This type is patent to the stomach but also connects with the trachea.

Dr. Berry: Do you think this patient had an "H" type esophago-tracheal fistula? How could you rule it out?

Mr. Stanley: No sir, it should have given trouble earlier—with the first feeding or so. The only way I know to rule it out definitely is by lipiodol studies, but she just didn't have enough trouble early enough and after every feeding to rule it in.

Tracheal tumors have to be considered—papillomas.

fibromas and angiomas, but these can't be ruled in or out definitely.

Then, mediastinal cysts could give this picture. Bronchogenic cysts may cause symptoms early, but they are most apt to appear later. Gastric cysts may be located behind the pleura and they usually cause symptoms early—but I didn't think much about these. Dr. Berry: What else did you consider?

Mr. Stanley: If you want to consider the club foot as a congenital anomaly along with the extra digit on the left hand and speculate on other hidden congenital defects being present you might consider Fanconi's syndrome.

Dr. Berry: And what else?

Mr. Stanley: I don't think hyaline membrane is compatible with her life span of about 6 weeks. You might think about some materials being present which she aspirated before or during birth and just never was able to get rid of. I think congenital cystic disease of the lungs must be considered, but this doesn't usually cause trouble referable to the respiratory system until later in life.

One must think also of congenital heart disease which might give episodes similar to those that she had.

Dr. Berry: Do you think she had congenital heart disease? She had other defects—why not speculate on some being present in the heart?

Mr. Stanley: I don't think she had congenital heart disease but I can't rule it out. This dullness in the left lung might have been due to an enlarged heart resulting from some congenital defect but no murmur was present. This would rule out some defects. Some of this weight gain starting on the 16th day of life could have been edema but that's just a guess and I couldn't back up any heart defect with it.

Dr. Berry: Mr. Williams, what is your opinion concerning this patient? Give the differential diagnosis, most likely diagnosis, and cause of death.

Mr. Julian Williams: My diagnosis agrees with the one suggested by Mr. Stanley, "vascular ring obstructing esophagus with aspiration pneumonia."

The condition of "vascular rings" occurs by the persistence of both arches of the aorta; thus, encircling the trachea and the esophagus producing symptoms of difficulty in swallowing and in breathing. The clinical symptoms of dysphagia, croupy cough, laryngeal stridor and cyanosis are due to pressure on the trachea.

In this case we note that the first mild episode of aspiration and cyanosis occurred on June 19, 6 days after delivery, with severe cyanosis and with aspiration on June 27. No history of coughing or laryngeal stridor was given.

With the symptoms in this case I first thought of tracheo-esophageal fistula; however, this can be ruled out on the absence of regurgitation for the first 6 days. Some must have occurred anyway to produce the pneumonia. The most common type, 80-90%, of the upper blind esophageal pouch can certainly be ruled out. The most likely type would be the one with

a fistula between both open esophagus and trachea; however, you would expect more severe symptoms earlier.

We may definitely diagnose pneumonia on the basis of poorly aerated lungs, temperature in 99's and spiking and decreased breath sounds, basing it all on an aspiration type of pneumonia. The cause of death, I attribute to aspiration pneumonia which the infant was unable to combat due to prematurity and to malnutrition.

The aspiration pneumonia is quite typical, with a possible history of intra-uterine fetal embarrassment, difficult resuscitation at birth, cyanosis, and respiratory distress, much mucous secretion, crepitant rales, and consolidation in areas of the lungs.

We also know that congenital anomalies are often present in numbers. The marked talipes equinovarus of the left foot and supernumerary digit on the left hand, with suspicion of some congenital condition causing clinical symptoms, make us consider the possibility of other anomalies. Congenital conditions which I think should be considered are short esophagus which I cannot rule out; congenital stenosis which is asymptomatic until solids are eaten; neurogenic lesions; and congenital hypertrophic pyloric stenosis.

Dr. Berry: How do you account for the anemia?

Mr. Williams: Again, I agree with Mr. Stanley that the anemia is insignificant in that it is relatively common in the premature infant and only begins to rise to normal values about the 12th week of age.

Dr. Berry: What are the types of congenital heart disease associated with cyanosis?

Mr. Williams: For cyanosis the condition must be such as to permit a right to left shunt of blood. This may occur at times in patent ductus (potential) and occurs in tetralogy of Fallot and in rudimentary right ventricle. We have no persistence of cyanosis here, but an intermittant type occurring immediately after or 15-20 minutes after feedings.

In conclusion, I think it very difficult to attribute the regurgitation and cyanosis to one specific thing; however, the most likely cause is a vascular ring. Aspiration pneumonia is the most likely cause of death.

Dr. Berry: Mr. Ackerman, what can you add to this discussion?

Mr. R. E. Ackerman: I think that, in the case of a premature infant who was anoxic for five to eight minutes after delivery, cerebral anoxia should be considered a definite possibility. This could result in petechial hemorrhages with later patchy areas of cortical atrophy. On this basis, the patient might have had damage to the respiratory center as well as to the temperature regulating mechanism, and this could account for the entire clinical picture.

I think, however, that this is probably simply the case of a premature infant who developed an aspiration pneumonia, with death primarily on this basis.

Another anomaly, however, which must be considered is that of the left coronary artery's arising

from the pulmonary artery rather than the aorta.

Mr. Ackerman: I think a vascular ring is a possibility, but I think that one would expect tracheal compression with a stridor, and this patient had no stridor. I think that a right aortic arch passing behind the esophagus with pressure on the esophagus resulting in regurgitation and aspiration of food with a resultant aspiration pneumonia is a possibility.

Dr. Berry: Does a right aortic arch ordinarily pass behind the esophagus?

Mr. Ackerman: No sir, I think it usually passes in front of the esophagus.



Figure 1. The aberrant right subclavian artery (2) compresses and distorts the esophagus (1).

Dr. F. E. Kredel: While, on first reading of the protocol, I was inclined to consider the possibility of a lateral or "H" type of tracheo-esophageal fistula, the delayed regurgitation fits esophageal obstruction better. Since congenital anomalies of the hand and foot are noted, one must think of a congenital lesion obstructing the esophagus, such as a vascular ring.

Dr. Berry: I should like to point out that this child was never in good enough condition to risk sending down to x-ray, consequently the exact diagnosis was never made clinically. I will call on the pathologists to give us their findings.

Dr. Forde A. McIver: The final pathological diagnoses in today's case included:

- (1) ANOMALOUS RIGHT SUBCLAVIAN ARTERY
- (2) CHRONIC PNEUMONITIS, PROBABLY ASPIRATORY

(3) IMMATURITY

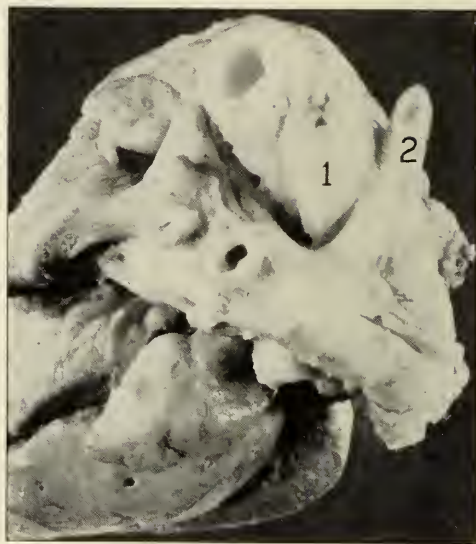


Figure 2. The aberrant right subclavian artery (2) arises from the posteromedial wall of the aortic arch and passes behind the esophagus (1).

These pictures (Figs. I and II) show how the aberrant artery caused difficulty. You see that it arises from the arch of the aorta just distal to the left subclavian artery and passes to the right side behind the esophagus and trachea. Compression of the esophagus is clearly demonstrated and no doubt resulted in repeated regurgitation and aspiration of secretions and formula. These intermittent respiratory insults produced a pneumonia which presents some features of lipoid pneumonia and others suggesting pneumonia of an interstitial type. In any case, pneumonia of this degree, together with immaturity, explain this child's clinical course and death.

It should be pointed out that, after coarctation and patent ductus arteriosus, an aberrant right subclavian artery is the most common anomaly of the aortic arch. It is explained, embryologically, on the basis of obliteration of the right fourth aortic arch and persistence of the right dorsal aorta. This condition is a great deal more common than the double aortic arch ("vascular ring") mentioned in today's discussion. Yet, it is true that an aberrant right subclavian artery may, and frequently does, persist for many years without producing symptoms. In later life, as the vascular system becomes less pliable, difficulty in swallowing may appear for the first time. Such a chain of events has been referred to in the past as "dysphagia lusoria"—a swallowing difficulty due to one of nature's practical jokes. The early and severe symptoms in this case may, perhaps, be explained by the smallness of the immature child and the exceptionally large aberrant vessel.

Had the condition of this patient permitted necessary diagnostic studies, ligation and division of the aberrant vessel should have produced a dramatic relief of symptoms.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring -----		82 Rutledge Ave., Charleston, S. C.	
EDITORIAL BOARD			
J. P. Cain -----	Mullins	Vince Moseley -----	Charleston
J. D. Guess -----	Greenville	Ben Miller -----	Columbia
C. J. Milling -----	Columbia	W. H. Prioleau -----	Charleston
H. R. Pratt-Thomas -----	Charleston	G. D. Johnson -----	Spartanburg
BUSINESS MANAGER: Mrs. C. G. Watson -----		R. M. Pollitzer -----	Greenville
		Hugh Smith -----	Greenville
		Walter Mead -----	Florence
		105 W. Cheves St., Florence, S. C.	

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) Charleston, S. C.
Subscription Price \$3.00 a Year

MARCH, 1954

THE PHYSICIAN AND VOLUNTARY HEALTH INSURANCE

Voluntary health insurance has assumed such large proportions in the last few years that it is now an important factor in the private practice of medicine. Not long ago it was the exceptional patient who had such coverage, while now it is so generally held there is hardly a physician who does not have to devote several hours a week to filling out insurance forms, besides providing additional secretarial help for this purpose. It is the means by which the citizen of moderate income can maintain his status as a private patient and accordingly have some choice as to physician and hospital. Furthermore it is a strong bulwark against the ever present threat of the complete socialization of medicine.

To continue on a sound basis, voluntary health insurance must be protected from abuses. In this respect physicians can play an important part. It is their moral obligation, as well as it is to their advantage, to do so. No company can survive on reasonable premium rates if it is called upon to pay for costly illnesses and operations which are anticipated by the insured at the time of taking out the policy. Upon learning that an operation is advisable, patients have been known to take out insurance and to change doctors so as to present a false claim as to dates. In stating dates concerning the onset and duration of illnesses the physician should be particularly careful to ascertain the facts and to adhere to the truth; the same applies to etiology. In some cases where the attending physician cannot be certain of the facts it may be advisable to refer such matters to the family physician. A com-

mon abuse is to admit a patient to a hospital for a particular condition and to order a lot of expensive diagnostic work not relevant to the illness for which the patient is being treated. The physician should not be a party to hospitalizing a patient at the expense of the insurance company to save the patient the cost of a minor operation which could be done on an out-patient basis. The same principle applies to keeping the patient in the hospital unnecessarily long.

Abuses of this type can only result in such increase in premium rates as to defeat the purpose of a sound insurance program. Physicians should exert their efforts to prevent them, though at the time it is difficult to refuse a patient what appears to be a reasonable request. In the long run it is to their advantage to do so, though in some cases it may cost them something in the loss of fees, and at times the loss of patients.

On the other hand there are instances in which patients should be protected from insurance companies. Some clauses relative to time of onset and etiology are so worded as to absolve the insurance company from any reasonable claim. A patient may have had a goitre or gall stones of many years duration though not have a suspicion of their presence at the time of taking out the insurance policy. In such cases it seems reasonable and fair that the illness should be dated from the time that the patient's health is affected or that symptoms appear rather than that of the formation of the gall stones or the beginning of the goitre. Insurance companies should recognize claims of this type and not search the hospital records for a way of escaping responsibility.

Most physicians try to fill out insurance forms honestly and correctly, but in many instances are handicapped by the complexity of the forms and the number of questions irrelevant to the particular case. A reform along this line is very much needed. A great many problems would be resolved if the effectiveness of the policy were based upon a specific date rather than the time of onset and the etiology of the disease. To complete some of the insurance forms would require the wisdom of a Solomon. The physician does not wish to assume such a role.

William H. Prioleau

DOCTORS HELP INCREASE THE COST OF HEALTH INSURANCE

Physicians, taken as a whole, are honorable men of high integrity. This is especially true in South Carolina where doctors know or know of almost every other doctor. Sometimes, though, we have a blind spot where insurance companies are involved. Utilization of health insurance all over the nation has risen since World War II. The rate for the nation is 130 per thousand subscribers. In South Carolina the rate is 166 per thousand subscribers. Health insurance is for the sick and should be used only for that.

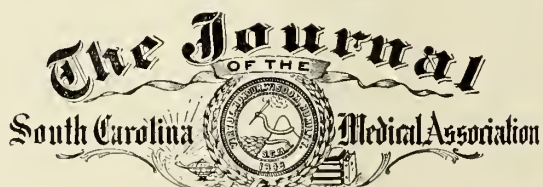
In South Carolina last year if the Blue Cross Plan had had 5 fewer admissions per month per hospital it would have saved \$250,000.00. If each patient's stay in the hospital had been reduced by one half day an increase in rates would not have been necessary. Obstetrical patients now leave the hospital in from three to five days whereas two weeks used to be standard. Herniorrhaphy and appendectomy no longer require a long stay in the hospital. Respiratory infections usually are cured in three or four days. Intractable vomiting associated with gastroenteritis usually responds to a clysis or intravenous in the office or emergency room and further treatment at home.

With a little thought and good management doctors can shorten a patient's stay in the hospital or prevent it altogether. Certainly a person with insurance is entitled to receive everything that the policy provides for if *those procedures are indicated* and that is where the rub comes. Hospitalization is indicated because

of sickness, not because of insurance, regardless of the pressure brought to bear by the patient.

Every automobile accident makes our automobile insurance higher. Every fire makes our fire insurance rate higher, every theft or burglary, every malpractice suit our malpractice insurance higher and so on. The patient, not the insurance company, will have to pay for greater and longer utilization. If we as doctors can save our patients money, there will be more money to pay the doctor, that's you and me. There are three major reasons for shortening the stay or avoiding admission to a hospital. First: it's right and fair; second: it helps the patient in the long run in his premiums; and, third: anything that helps our patients helps you and me.

G. D. Johnson



Forty Years Ago

March 1914

Florence, meeting place of the Association, was described in an extensive article, garnished with "soft sunlight splashing the forests . . . and . . . the enchanting music of the mocking bird"—In the photographs no single automobile mars the streets of the business district. Dr. John Townsend of Charleston was to read a paper, as was Dr. R. M. Pollitzer, then likewise of Charleston. Dr. J. H. Gibbes of Columbia was to speak on Chronic Infections. Dr. Paul Switzer was welcomed to the Union County Society.

AMERICAN MEDICAL EDUCATION FOUNDATION

The American Medical Education Foundation and the National Fund for Medical Education are entering their fourth year of operation. In the three years of existence, \$4,764,-152.79 has been distributed to the medical schools of this country.

In the consideration of such figures one must

admit that these agencies are going concerns. However, there appear to be misconceptions as to how this money is derived and on what basis it is distributed. The funds of the National Fund for Medical Education come from two sources: (1) The American Medical Education Foundation, which is supported by the American Medical Association and has derived its income from physicians alone; and (2) by direct solicitation from industry.

When industry was originally approached by interested persons to solicit their support of medical education, it was pointed out to them that the medical schools of this country were in dire straits. The cost of medical education had risen apace and it was obvious that additional support must come from some source, either from private resources or government subsidy. Fearing the inroads of government subsidy, the National Fund was formulated to enlist the assistance of industry. The work of this group is of such stature that they were incorporated by special act of Congress. The first question asked of them was "What are the doctors themselves doing about it?" This is now answered by the fact that the American Medical Education Foundation has turned over to the National Fund for distribution to date \$2,462,304.78.

This is a good beginning but, in spite of the astronomical appearance of these figures, it is not enough when it is considered that the 79 approved schools of medicine in the United States train approximately 27,000 undergraduates and 55,000 other medical scientists taking postgraduate work. They graduate more than 6,000 doctors annually, 1,000 more than a decade ago, but not enough to keep pace with the ever-increasing demand. Strong, self-reliant, well-staffed medical schools are a keystone of the national welfare. It would be tragic indeed if the activities of our medical schools were curtailed.

Today it is estimated that \$5,000,000.00 is needed to meet urgent medical school problems. Another \$5,000,000.00 is needed to overcome equally pressing long range problems. The average cost of training a doctor has doubled in 20 years to \$10,000.00. Many schools have raised their tuition since 1940, but this is only a small portion of the increase

which is needed to meet the rising cost of medical education. There is grave risk that research activities and scientific advance will be stultified by lack of personnel in full-time medical college positions.

The goal for the National Fund for Medical Education for 1954 is \$10,000,000.00. The American Medical Education Foundation has accepted the problem of a goal of \$2,000,000.00 from physicians. In order to meet this goal it will require at least a \$10.00 contribution by every practicing physician in this country.

As an opening and in order to show its endorsement, the Medical Association of South Carolina voted \$10,000.00 to be placed in this fund. Since that time (1951) South Carolina has depended on voluntary contributions which have been extremely disappointing. In that first year, by reason of the \$10,000.00, South Carolina ranked third among the states in the support of this effort. However, in the year 1953, South Carolina's position was second from the bottom. This is in spite of the fact that our Association vigorously supported this movement at its beginning.

It is to be pointed out that contributions need not be of large sums, although of course it is desirable, but small contributions are gratefully received.

In order that a physician may display his loyalty to his own school, he may, if he desires, earmark the money that he contributes to the support of his own school or any school of his choice.

It is repeatedly emphasized by the administrators of both of these funds that none of the money contributed by physicians is used for administrative purposes at all. The American Medical Association supports the expenses incurred by the American Medical Education Foundation and none of the money contributed by doctors goes to any other purpose than the support of medical schools. The fund accumulated by subscriptions not earmarked is apportioned to the 79 medical schools on an equal basis, the two year schools having half of that of the four year schools. In addition, money is prorated on an enrollment basis.

The money, after distribution to the medical school has no restrictions placed upon it. The

administration of the medical school can use this money for any purpose which it desires and by this token it is invaluable.

Donations to medical education are undoubtedly a worthwhile project. It would be well if every physician in the United States determined that he was going to use the American Medical Education Foundation as one of his income tax deduction avenues. The address is: 535 N. Dearborn Street, Chicago 10, Illinois.

J. T. C.

Omnia in Risu

IT'S ALL IN FUN

When Joe Waring said to me, "Boy, you ought to do something for the profession that has made you what you are—little as you may be," I thought, "What can I do to help medicine out of this terrible mess it's in." The answer coming back via several of my professional colleagues was unanimously, "NUTHING." However, I did feel that with the help of some of my more enlightened colleagues (who would give me some active reading material) I could make "Omnia in Risu" worthwhile and presentable.

Now, I suppose that all of us have met or even worse are intimately associated at times with a colleague who might fit in the following story.

The bridegroom, Rastus, with his bride showed up at the office of the Justice of the Peace asking him to tie the long lasting and eternal knot. The old justice sitting from his seat of Local Law looked over the license and said, "This license doesn't have the date on it; you will have to take it over to the clerk of court and have that fixed." "Judge," Rastus said, "You know the date; can't you just put it in and go ahead and marry us?" "Oh, no," replied the judge "You will have to go back to the Town Hall and get it fixed." Back went Rastus and his near bride, up to the town clerk who affixed the date and back to the Judge.

The old justice looked it over. "H'm," he h'med, "It looks like the clerk forgot to put in your girl's maiden name. Take it back over to the clerk of court and have him fix it." But, the anxious bridegroom pleaded, "The Town Hall is all closed up and the clerk has gone home, can't you put her name in for us?" In all his judicial dignity, the old Judge said, "Now look here, son, I don't go around tampering

with legal papers—you go right back and have that clerk of court fix the papers properly."

Over to the Town Hall rushes Rastus and the Frantic Lady of his life. They finally catch the clerk who makes the necessary additions and back to the Judge they go.

After finally satisfying himself that things were in good order the kind old Judge pronounced Rastus and his bride, Man and Wife. Then for the first time, the Judge noticed the four-year old boy in the room. "Whose child is that?" "Ours, Judge," Rastus replied. Somewhat taken aback, the Judge asked, "You mean . . . you had the child before---?" "Yes," said Rastus, "before we were married."

"Well," the old man said, "Of course you're married now but you must realize that this child is a technical bastard." And watching the look of surprise on the faces of the now married couple, he said, "I suppose you know what a technical bastard is, don't you?" "Why, Yes Sir we shd do, that what the town clerk said you were."

Perhaps there's a lesson for us. It does seem that being perfect in the practice of medicine is most desirable but isn't it a shame that some of us become so technical that we become illegitimate? Of course one wonders whether the individual is technical first and then becomes an illegitimate or if the illegitimacy comes first and he is born technical in his illegitimacy. Rather confusing to say the least and perhaps much ado about nothing. My old Grandmother used to say, and now I quote her "There ought to be at least one marriage in every family." We have always adhered to that line of thinking and while we has no real technicians in our family, neither do we have any B.s.

NEWS ITEMS

Dr. R. C. Smith has been reelected president of the staff of Conway Hospital.

Dr. Edward Proctor was elected vice president, and Dr. Wayne Reeser was chosen secretary-treasurer to succeed Dr. Howard Smith.

The medical staff of Conway Hospital consists of 17 members on the active staff, all resident in Conway, and six members of the courtesy staff, who live in Horry County.

Heading the staff committees for 1954 are Dr. R. C. Smith, chairman of the executive committee; Dr. Clarence Legerton, chairman of the records committee, and Dr. deSaussure Gilland, chairman of the tissue committee.

Three Ware Shoals physicians are joining together to form the "Ware Shoals Medical Clinic."

Dr. F. C. McLane, well-known Ware Shoals doctor, is moving his offices and equipment to the building on East Main St. now occupied by Dr. H. B. Morgan and Dr. W. J. Holloway. The new "Ware Shoals

Medical Clinic" office hours will be 8 a. m. to 5 p. m., offering medical treatment to the Ware Shoals community.

Dr. William M. Ragsdale and family have moved to Myrtle Beach from Lake City, and have purchased the house on 64th Avenue North. They plan to make Myrtle Beach their permanent home.

Dr. Ragsdale will share offices with Dr. Carey T. Durant and participate in the general practice of medicine in Myrtle Beach.

Dr. Vance W. Brabham has resigned as City Health Officer of Orangeburg. Dr. John W. Dantzler has been appointed to succeed Dr. Brabham.

Plans were announced by the county board for a 30-bed \$300,000 hospital to be built in Woodruff. It will be a subsidiary of Spartanburg General Hospital.

Dr. M. L. Marion of Chester has been elected chief of the medical staff at the Chester County Hospital for the ensuing year. Dr. Marion succeeds Dr. V. P. Patterson of Chester. Dr. A. J. Reinovsky of Great Falls was elected vice president, and Dr. C. W. Brice, Jr. of Chester, secretary and treasurer.

Ground-breaking ceremonies marked the beginning of construction on the 42-bed Barnwell County Hospital, expected to be completed within a year.

A local hospital is now being constructed at a cost of \$528,000 at Winnsboro.

It is a 30-bed, fireproof, cross-shaped building for white and Negro patients and can be increased to 50 beds.

Approximately 125 physicians and surgeons of the two Carolinas attended the thirty-third annual meeting and banquet of the Marlboro County Medical Society on January 14 at the Country club. The dinner was served by the Junior Charity League of which Miss Eleanor McColl is president.

The speaker of the evening was Dr. David James of Atlanta, who presented some practical aspects on the management of patients with liver disease. Dr. Charles R. May, president of the host Medical Society, presided.

Distinguished guests attending, in addition to Dr. James, were Dr. Richard Baker of Sumter, president of the South Carolina Medical Association; Dr. Julian Price of Florence, member of the board of trustees of the American Medical Association, and Dr. Kenneth Lynch of Charleston, president of the Medical College of South Carolina.

The National Foundation for Infantile Paralysis announces the availability of a limited number of post-doctoral fellowships in the field of public health and preventive medicine. The purpose of these National Foundation fellowships is to prepare physicians to fill the many vacancies existing in public health and preventive medicine, with priority to those who are interested in entering the teaching field.

Dr. Orin Yost, formerly of Orangeburg has opened offices at 211 John Anderson Highway, Ormond Beach, Florida, with practice limited to psychiatry.

Dr. Walter B. Martin of Norfolk, Va., president-elect of the American Medical Association, was special guest (guest speaker) during the monthly meeting of the Columbia Medical Society held on January 11 at the Columbia Hotel.

CORRESPONDENCE

Dr. Robert Wilson
Charleston, South Carolina

Dear Dr. Wilson:

I am a licensed physician, a graduate of Loyola University Medical School, at present completing the first year of a residency in internal medicine. I am desirous of obtaining a locum tenens position for the months of July, August, and September, 1954. Any type of position would be satisfactory provided I am able to make the best use of this time in experience, and financially, as I hope to finance the remainder of my residency.

I am 27 years of age, married, with two small children. I would appreciate whatever information you may be able to provide as to possibilities for securing a locum tenens position in your state, and the procedure for obtaining same.

Thank you for your assistance.

Yours truly,
Edwin F. McNichols, M. D.
4057 North Sherman Blvd.
Milwaukee, 16, Wis.

DEATHS

H. M. DANIEL

Dr. Homer M. Daniel, 60, well known civic and religious leader of Anderson and for many years one of the most widely known urologists in this area, died at the Veterans Hospital in Columbia January 14 following several months illness.

Dr. Daniel had been in partial retirement since 1946 due to ill health, and suffered a severe stroke about a year ago. He was removed to the veterans hospital last July, and had been a patient there since that time.

A native of Elbert County, Ga., Dr. Daniel was born June 12, 1893, and was graduated from the Emory University School of Medicine in the class of 1916.

Dr. Daniel first began the practice of his profession in the Roberts section of Anderson County, later locating in Anderson following his return from service in World War I.

During his long residence in Anderson he had been prominently identified with the civic and religious life of the community.

BOOK REVIEWS

Regional Block, Daniel C. Moore, M. D., Director, Department of Anesthesiology, Mason Clinic and Chief, Anesthesia Division, Virginia Mason Hospital, Seattle, Washington. Charles C. Thomas, Springfield, Illinois, 1953, 345 p. p. and index, 433 illustrations, \$11.00.

The author divides his book into two parts. The first nine chapters emphasize fundamental considerations involved in all types of regional anesthesia. The necessary instrumentarium, the available anesthetic drugs,

and the basic methods of manipulating needles and syringes are clearly and concisely outlined. An entire chapter is devoted to the diagnosis and treatment of toxic reactions produced by the use of the regional anesthetic drugs.

The second part describes in minute detail an anatomical approach to the innervation of the various areas of the body. Only one clinically tested approach is cited for each nerve block, yet this justifiable brevity permits, instead, the use of many clear drawings of a semi-diagrammatic form and photographs of actual anatomical dissections of the area. Topical landmarks, in many instances, are clearly illustrated by the use of a skin crayon.

The book is attractively and securely cloth bound by the publisher. The print is large and striking variations in the size and boldness of the headings enhance the readability. The paper is of excellent quality.

The general practitioner, the surgeon who is frequently called upon to perform his own diagnostic and therapeutic nerve blocks, and the anesthesiologist who does an occasional nerve block should find this book desirable. It should prove exceedingly useful as a primer for students desiring a basic foundation in regional nerve blocks before attempting the more complicated, hazardous and less frequently employed nerve blocking procedures.

John Brown

Review of Physiological Chemistry—Harold A. Harper, Ph. D. 4th Edition, 319 pages—Lithographed type—Paper back—(University Medical Publishers, Los Altos, Calif.) Price \$4.00.

This book presents a comprehensive summary of the fundamentals of Physiological Chemistry. Emphasis is placed upon accepted facts and concepts with little of a controversial nature included.

For review, this book presents an excellent outline for the physician who wishes simply to review the subject. For the beginning student it presents an excellent outline of the subject for use with a standard text and with a series of lectures or explanations.

A distinct criticism, however, of this book, from a physician's point of view, is the lack of specific clinical applications of the subject of chemistry to medicine. On this basis it is doubtful that the physician would find this book of much interest.

Wm. McCord

A Source Book of Medical Terms—by Edmund C. Jaeger D. Sc. — Illustrated — Charles C. Thomas, Springfield—Price \$5.50.

From the literary standpoint, much of our medical writing is bad, even after editorial scrutiny. Compare our current journals with those of the British, and see how much better the latter are in readability and in conformity to simple grammatical writing.

Those of us who are given to coining new terms and stretching the meanings of words may well be restrained from too much error by referring to this source book. It gives us the basic origins of words used in medicine, their history and development and their special application. It gives also brief rules used in the synthesis of words.

Nowadays there are fewer and fewer of us who are familiar with the Latin and Greek from which so much of our terminology stems. This book provides a guide and a short cut to the hidden meaning of words unfamiliar to us, and shows by many illustrations the relation of terms used for structures roughly similar—e. g. *ethmos*, a sieve, and the *ethmoid* bone.

With this volume in reach of a ready hand, the average medical writer should be well guarded against the barbarisms which he is rather likely to perpetrate, and should be able to make more telling use of the words which are here dissected for him.

J.I.W.

Respiratory Diseases and Allergy—New Method of Approach by Joseph S. Simul, M. D., Medical Library Company, New York 1953—Price \$2.75.

This new approach to respiratory disease adds little, if anything to current knowledge and tends to confuse by the addition of different classification and terminology the already large and vaguely defined field of allergic diseases of the respiratory system.

K. McKee

Diseases of Women, Robert James Crossen, M. D., F. A. C. S., The C. V. Mosby Co., St. Louis, Mo., 10th Edition, 1953, 935 pages, 990 illustrations, 41 color pages, \$18.50.

One's attention is immediately attracted to the bright blue cover with the title "Diseases of Women," in gold against a red background, making the cover more appealing to the eye. This adds rather than detracts from the book, and "eye appeal" is carried further in that the printing is easier to read.

There have been many additions to this book and some worthwhile deletions. The bibliography is now placed at the end of each chapter or special section, which is a definite improvement over the previous editions, where it was placed at the rear of the book. Two special sections have been added and these are: "Endocrine Relations Concerned in the Ovarian Cycle" and "Radiation Therapy." The absence of a discussion of the complications of irradiation therapy for carcinoma of the cervix is sorely missed. The omission of several chapters in the new edition is to conserve space; however, the omission of the chapter "Gynecologic Treatment Measures" will not be missed, for many of the treatments have been discarded.

There is an excellent chapter on "Gynecologic Examination and Diagnosis;" however, I feel that the subject of rectovaginal examination, should have more than a short paragraph devoted to it. Much can be learned on rectovaginal examination that cannot be learned on a vaginal and a rectal examination and its place as a routine part of the gynecologic examination, cannot be over-emphasized.

Notwithstanding the fact that there are other minor points of disagreement, the author and publishers have done an excellent job and are to be congratulated. This book has a place in the library of medical students, general practitioners, obstetricians and gynecologists.

Lawrence L. Hester, Jr., M. D.

Pelvic Relaxations and Herniations By James M. Wilson, M. D., Assistant Professor of Gynecology and Obstetrics; Medical College of South Carolina.

Charles C. Thomas, Springfield, Ill.—Price \$2.75.

To know and to have an affectionate regard for an author enhances interest in his writings. Since Dr. Wilson is well known and regarded in his native and home state and in North Carolina, where he did his residence work at Duke University, this, his first published work, will elicit widespread interest in this territory.

This little book of some sixty pages was written, says the author in the foreword, for students. Actually, he did not limit it to undergraduate students, and its interest will extend to residents in obstetrics, in gynecology and in general surgery and to practitioners who include the perineum and pelvic structures in their field of interest and practice.

The anatomy and the functional stresses involved in the soft tissues of the female pelvis are notoriously not understood or are misunderstood. Difficulties in obtaining cadavers with uninjured or normally developed pelvic supports, together with the difficulties involved in dissection, have made it necessary for the average student of the subject to obtain his information either piecemeal at the operating table or

from the descriptions and drawings of others. This book will serve as an instructor in the latter category.

Its illustrations, done by Elon Henry Clark of the Department of Medical Art Illustration of Duke University, are well done and easy to understand. The text is well integrated with the illustrations, making the exposition clear.

The book is divided into ten chapters. The first deals with the clinical anatomy of the normal female pelvis. There follow in succession and more or less in the order of the incidence of the conditions treated, chapters on rectocele, cystocele and urethrocele, urethrocele and incontinence, prolapse of the uterus, prolapse of the vaginal vault after hysterectomy, episiotomy, posterior vaginal hernia, levator hernia, obturator hernia, sciatic hernia and herniation into the broad ligament.

The book is not an operation manual. Instead, as the author stresses, "The indication for surgical interference and the principle of repair are considered." As would be expected, coming from the Medical College of South Carolina, the attitude expressed, even stressed, with regard to pelvic surgery, is conservative.

J. Decherd Guess

Salt and the Heart, by E. T. Yorke, M. D. (E. T. Yorke, 1717 N. Wood Ave., Linden, N. J.) Price \$3.45

This seems to be an excellent book to recommend to patients who must be put on low sodium diets. It is a well balanced discussion of the subject in terms understandable by the intelligent layman, and some intelligent doctors could read it with benefit. Not a cookbook.

J. A. Boone

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. David A. Wilson, Greenville, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

OUR BEST ANSWER TO PROPAGANDA GOOD MD-PATIENT RELATIONS FOSTERED VIA MAGAZINES

With the help of America's writers and advertisers, 1954 may usher in a new era of increased doctor-patient understanding and mutual good will. Here are some examples of how medicine's positive story is being told: Getting the year off to a good start, Parke, Davis & Co. scheduled a public service advertisement on "how to select a family doctor" for the January 11 issue of LIFE. The ad will also appear in Saturday Evening Post, Woman's Home Companion, Parent's Magazine and Today's Health.

In recent months, Better Homes and Gardens (Nov., 1953) published an article entitled "When You Need a Doctor in a Hurry—What Will You Do?" Rotarian (Dec., 1953) ran an article called "Don't Kill Your Doctor," and Look in the Nov. 17, 1953, issue told how "Mississippi Trains Its Own Country Doctors."

A. M. A. has a few copies of these articles. Please let them know if you need them.

Other recommended reading:

Not As A Stranger by Morton Thompson. The Literary Guild brochure, "Wings," says of this book: "This is the story about a doctor, a man so dedicated to his work that he almost lost the deep human values in his own personal life. This is also a story about the entire medical profession . . . a powerful, behind-the-scenes revelation which takes you straight into the consulting rooms, and opens up the private, hidden lives of patients and doctors alike. This is a stupendous book which has the ring of finality, as though here, at last, in novel form, the subject of medicine has been rendered complete. No doctor would have dared write *Not As A Stranger*—it exposes too much about the profession. Its brilliant author, Morton Thompson, spent many years in researching his book . . . until he knew more about the medical profession than many doctors. This novel is a real reading experience."

BILL "S389"

Auxiliary members are urged to become acquainted with the bill in the South Carolina legislature known as Bill "S389." This bill is one which is concerned with the placement of juvenile delinquents, while they await trial, as well as after their offenses have been tried and sentence has been passed.

If the juvenile offender is arrested or sentenced to imprisonment, whether for long or short duration,

there is no suitable place for incarcerating him in most of the counties of the state. In a few large cities there have been for some time juvenile courts and accommodations for the punishment for their offenses. But there are numerous examples all over the state where children in gangs or under bad influences have committed crimes and have been lodged in jails with hardened criminals for long periods of time, simply because there was no other place for them.

This bill is one which arouses our interest and command our attention, not as auxiliary members, but as citizens and mothers and individuals who have all health interests at heart. This bill, providing a statewide system of adequate handling of convicted juvenile delinquents, would certainly affect materially the physical, mental, and moral health of the youth of the state.

Legislators who have been reached say that the bill will not be passed unless there is some feeling expressed, some pressure brought to bear by an aroused public.

Public Relations Committee

EDISTO AUXILIARY AIDS IN ORGANIZING GREY LADIES CORPS

The Edisto Medical Auxiliary has one new little feather in its cap. It has been instrumental in helping the local Red Cross institute a Corps of Grey Ladies in the Orangeburg Regional Hospital. A number of the doctors' wives took the orientation course along with other interested women of the community and after six weeks are ready to receive their caps and pins. Mrs. J. M. Albergotti, Jr., and Mrs. G. M. Truluck were the two auxiliary members who met with Red Cross officials to "start the ball rolling."

Among the specific jobs undertaken by the Grey Ladies have been the cleaning and straightening of the hospital library and the establishment of an information desk in the lobby, which relieves the telephone operator of interruptions by visitors seeking information. Numerous other services are rendered by these volunteers and as time goes on their presence will be felt even more in the hospital.

TODAY'S HEALTH NEEDS YOUR SUPPORT

All Auxiliary members who are proud and happy to do all they can to support positive health education and positive public relations, should support Today's Health.

Don't delay any longer in making an honest effort to increase the sale of subscriptions to Today's Health.

By placing it in physicians and dentist's offices, school libraries, barber shops, beauty parlors, etc., we are helping to bring "accurate views and considered advice of outstanding and dependable medical authorities to the general public in terms that it can understand."

Dr. W. W. Bauer, the able editor of Today's Health, states, "The current operational deficit of the publication would be practically eliminated if every member of the American Medical Association, would become a subscriber."

Your state chairman urges every member of the auxiliary to see that your husband subscribe now to Today's Health and places it in his reception room. It's a "good buy in public relations."

Send all subscriptions to:—Today's Health Circulation, 535 N. Dearborn St., Chicago 10, Illinois.

Orders from Auxiliary members, M. D. and D. D. S. are: 1 year \$1.50, 2 years \$2.50, 3 years \$3.25, 4 years \$4.00. The regular rate is \$3.00 a year for others.

Mrs. J. W. Bell, Chairman
Today's Health

PRELIMINARY PROGRAM FOR THE ANNUAL MEETING OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

Myrtle Beach, S. C.—May 11, 12, 13, 1954

Tuesday, May 11, 1954—Meeting of the House of Delegates.

Wednesday, May 12, 1954—2:00 to 4:00 p. m.

Panel on Non-Tuberculous Diseases of the Chest

Moderator: Dr. D. T. Smith, Durham, N. C.

Medicine: Dr. John Seabury, New Orleans, La.

Pediatrics: Dr. Richard W. Blumberg, Atlanta, Ga.

Surgery: Dr. Rollin A. Daniel, Nashville, Tenn.

Radiology: Dr. Harold Pettit, Charleston, S. C.

Wednesday, May 12, 1954—4:00 p. m.—"The Changing Epidemiological and Clinical Pattern of Pulmonary Tuberculosis"—Dr. D. T. Smith.

Thursday, May 13, 1954

9:15 a. m.—Memorials.

9:30 a. m.—President's Address—Dr. C. R. F. Baker, Sumter, S. C.

10:00 a. m.—"Emergency Treatment of Head Injuries"—Dr. William H. Bridgers, Columbia, S. C.

10:30 a. m.—"The Treatment of Common Skin Diseases"—Dr. Kathleen Riley, Charleston, S. C.

11:00 a. m.—"The Value of Exfoliative Cytology in Diagnosis"—Dr. Rawling Pratt-Thomas, Charleston, S. C.

11:30 a. m.—Time for Visits to Exhibits.

11:45 a. m.—"Common Proctological Problems—Dr. Louis A. Buie, Mayo Clinic, Rochester, Minn.

1:00 p. m.—Luncheon.

2:30 to 4:00 p. m. — Obstetrics — Gynecology — Pediatric Panel. Post-maturity and other neonatal problems

Moderator: Dr. Wm. DeLoache, Greenville, S. C.

Pediatrics: Dr. Amos Christie, Nashville, Tenn.

Obs.-Gynecology: Dr. Norman Thornton, Charlottesville, Va.
Also

2:30 to 4:00 p. m.—Medical-Surgical Panel on Peptic Ulcer

Moderator: Dr. Henry Mayo, Charleston, S. C.

Internist: Dr. Franz J. Ingelfinger, Boston, Mass.

Surgical: Dr. Cranston W. Holman, New York, N. Y.

Radiologist: Dr. George J. Baylin, Durham, N. C.

4:00 p. m.—Visits to exhibits.

4:15 p. m.—"The Treatment of Liver Disease,"—Dr. Franz J. Ingelfinger, Boston, Mass.

5:00 p. m.—Adjournment.

7:00 p. m.—Cocktails. (Courtesy of Van Pelt and Brown).

8:00 p. m.—Banquet. Address by The Hon. James F. Byrnes

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

THE FUTURE OF PRIVATE PRACTICE

Addressing the Medical Society of the County of New York in January, as reported in New York Medicine, Dr. Chester S. Keefer, Special Assistant to the Secretary for Health and Medical Affairs of the U. S. Department of Health, Education and Welfare, made some interesting forecasts with respect to the future of the private practice of medicine in this country. He acknowledged that any predictions concerning this subject are "extremely hazardous," but in view of the discussion which has taken place within the past fifty years, he points out that it is well to review the subject periodically. He quoted a pertinent paragraph from an essay on the same subjects by the late Dr. Frank Billings in 1921, which serves to emphasize the fact that the current situation had its beginnings at least more than thirty years ago, and that they are, to some extent at least, inherent in the nature of the economic development of the United States:

"In the evolution of modern life, society has been and still is characterized by financial greed and by extravagant expenditures for luxuries and pleasures which appeal to the physical rather than to the spiritual man. The cities afford opportunity for display, social pleasures, and for possible success in a professional and financial way. This tempts migration of the professional and the business man, including the young men of the farm, from the country to the city. This migration has increased within the last few years in spite of the more livable conditions of village and rural life, through the advantages of rural free delivery, the inter-urban trolley and motor cars. At the present time more than half the population of the United States is urban. Thus there is an excess of physicians beyond the need of the city public, and a dearth of medical men to supply the need of the rural population. This breeds discontent and disappointment in the medical profession in the city, and the rural public suffers from the need of a sufficient number of doctors. The country physician lacks modern facilities for diagnosis and for the needed hospital treatment of his patients."

Dr. Keefer believes that "The trends and shifts of emphasis in medical practice indicate that the physician and the profession will determine the nature of medical practice in the future as in the past. However, the medical profession will determine their future and their destiny only if they continue to consider themselves a part of the general public. The profession must be devoted to the welfare of the public and continue its practice and pursue the art of medicine as a public service. The tradition of the medical profession is a duty to the patient, to the profession, and to the public."

Stressing further the obligation and the opportunity of the medical profession in determining its future, the

speaker made these observations, with which, of course, we are all quite familiar and in agreement, but which some are perhaps prone at times to overlook:

"All physicians have rights as citizens and as a profession. But, in addition to rights, the medical profession has certain privileges and prerogatives which are allowed by the people and enjoyed under the law. These privileges are permitted by the public by reason of confidence in the integrity of the profession and in the belief of its general beneficence and by right of specialized knowledge. The medical profession exists only as the people allow it to maintain its prerogatives. We should be acutely aware of these privileges and appreciate what the profession enjoys. Those who are conscientious will not take advantage of these privileges. Those who are thoughtless—and certainly those who are not entirely honest—will do so."

He called attention to an expression by Dr. Atehley of Columbia University in a recent issue of *The Saturday Review*, to the effect that "the medical profession has only recently progressed to the synthesis of its own separate and often antagonistic aims through fusion of the old art of healing with the relatively new science of medicine;" and Dr. Keefer believes that each physician, individually and through his medical society, is contributing toward that "synthesis" in his work toward improving public relations, physician-hospital relationships, voluntary health insurance, and the level of public understanding of health problems.

Developments which have contributed largely to the change in the private practice of medicine were interestingly traced. The effect of some of these developments is by no means complete, but will continue to be felt in greater degree in the years to come. Apparently, it is Dr. Keefer's idea, also, that the continued interplay of certain of these developments will lead eventually back to some semblance of the relationships between patients and patients' families and the physician which were so highly prized a few decades ago, and that the relationships will be vastly improved and made more highly satisfactory to patient and physician alike. These elements were discussed:

"*The Family Doctor*. In 1923, about 1 in 10 of the 146,000 physicians in the United States limited his practice to some specialty. In 1949, the proportion of full specialists had increased to 3 in 10. The decline in the resulting proportion of physicians who gave all or part of their time to general or family practice is perhaps one of the most deplorable developments in the period and may well be at the root of many of the problems of medical care today . . . Nostalgically the patients of today look to all physicians for the same type of sympathetic interest in their personal problems; yet at the same time they want the best in modern scientific medicine. The family doctor of 30

years ago would have been puzzled at the need to write books with such titles as 'Patients are People,' 'Patients Have Families.' Increasingly the doctor of today and tomorrow, as healer and scientist combined, will find satisfaction and reward in family practice, for medicine is being guided back to primary preoccupation with a person as a human being."

Dr. Keefer sees the doctor of the future "as the most important single unit in medical care." He thinks that, "Like the family doctor of the past, the family physician of the future should serve as health advisor and health educator and as a leader in developing the health resources of the community." By reason of the vastly greater resources at his command, however, the family doctor of the future will differ greatly from that of the past.

"Specialism. The specialist is and will of course remain an essential, necessary and important person in medical care. As medical knowledge expands, new specialties will emerge, each requiring years of study to assimilate and augment techniques of diagnosis and treatment. In the future, however, specialists can be used more wisely if their services are properly correlated with those of the family doctor.

"Our problems of the past have derived mainly from the isolation of the various specialists from each other and from the lack of 'generalists' to interpret and integrate the several fields. In pediatrics, however, and in the emerging specialty of geriatrics, the specialists are also generalists for a whole age group. We need to develop equally rewarding concentration on the total person in his most productive years of life. The family doctor will help to fill this gap."

Group practice for home and office care is a more recent but considered an equally significant development. It is said to achieve "economy by avoiding duplication of expensive equipment and that it ideally provides the link between the personal physician and a wide range of specialists." The upward trend in this type of practice is indicated in the rise from a total of 239 groups in 1932 to an estimated 500 in 1950, and this, said the speaker, is expected to continue.

Hospital Care. The far wider use of institutional care is of course generally recognized and understood. According to Dr. Keefer, admissions to registered hospitals in 1934 represented 61 persons per 1000 population, and by 1952 the admission rate reached 121.4 per 1000 population. The tendency toward development of separate and specialized types of institutions for the care of chronic or other long-term cases was pointed out, along with the recognition of the need for nursing and convalescent facilities and home-care programs. The importance of this particular phase of hospitalization was given unusual emphasis lately through the recommendation by President Eisenhower in his Health Message to Congress for amendments to the Hill-Burton Law in order to permit the use of Federal funds for the building of such hospitals.

Medical Care Insurance. The remarkable growth and expansion of medical care insurance was referred to as "an almost revolutionary factor in medical prac-

tice." In Dr. Keefer's opinion, and despite the number of people covered by some form of such insurance, the present provisions have several serious gaps:

"1. The effect of health insurance on the utilization of physicians' services for periodic health examinations and home and office care should be extended. A 1952 Medical Economics Survey found that private practitioners see nearly three-fourths of the average daily number of patients in their offices. Home visits and hospital visits represented about one-tenth and one-fifth, respectively, of their daily patient load . . .

"2. Ways must be found to extend health insurance protection to individuals as well as to groups and to cover aged, retired people and those with existing health defects. To maintain solvency and to keep premiums within the range of most family budgets, insurance agencies find it necessary to avoid or minimize the danger of covering a large proportion of unhealthy people . . .

"3. Ways must be found to expand and intensify rehabilitative efforts so that persons suffering from disabling chronic illness and defects may be restored to usefulness."

The role of research and education was recognized as a most important one. In the words of the speaker, "As teachers, practitioners, research workers, and community leaders we *build* the future of medicine from our knowledge and experience of the past." And, he pointed out, our resources in this particular task are many, and both public and private support for medical education can be depended upon.

The Federal Role. In summarizing the role of the Federal Government in connection with these expected developments in the private practice of medicine, Dr. Keefer outlined fairly closely the suggestions and recommendations which have been made by the President in his State of the Union message and his Health Message in January. He believes that "our new approach" to the solution of the problems in filling the gaps in voluntary insurance through co-operative effort "assures sound solutions without the danger of Government control of medicine," and he thinks that the problems that lie ahead for the private practice of medicine must be studied and determined by professional and lay people alike in a sense of fairness and with the desire to afford justice for all concerned.

"In considering the measures which must be instituted to improve the health of the people and the future practice of medicine, we as a profession must keep in mind the general welfare of the public."

HOMEOPATHIC BOARD PROPOSED

There is good reason to believe that the bill (S.504) introduced into the Senate on February 3, 1954, for the purpose of authorizing the creation of a Board of Homeopathic Medical Examiners is not all it may appear to be on its face, or on the other hand, that it may be considerably more. A little less than a year ago, the Executive Offices of the South Carolina Medical Association received information in writing from a most reliable source to the effect that such a bill

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications ¹	Side Effects Requiring Discontinuance of Drug ²	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ¹			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiasen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segaf, Friedman, Watson	34	34	34 ⁴				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ¹			18			
Maier, Meili	38	38	24			14 ⁴	27	7	4 ⁷				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Poth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ⁸	
Legerton, Texter, Ruffin	11		11				11									11
Holoubek, Hofoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ⁹									42
Sharken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					4 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES			67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3		3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only; no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past three years, more than 250 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 783 patients on whom reports were available.

In all but 9.3 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. SEARLE & Co.
P. O. Box 5110, Chicago 80, Illinois

would be introduced in South Carolina. Included with the letter were copies of correspondence indicating very strongly, or leading to the almost inescapable conclusion that the general purpose of the introduction of the bill and the legalizing of the issuance of license to practitioners there under would be to make possible the securing of homeopathic licenses with little regard to the training and qualifications of the applicants. A portion of the information which was brought to our attention at that time was quoted from a Naturopathic publication, and dealt with the activities of "a certain past president of a naturopathic association." In all fairness, it must be stated, that the attitude of the publication and others involved at that time was strongly condemnatory of the proposed move. On the face of the information presently available, there is no apparent connection or relationship whatever between the sponsors of the proposed measure and recognized practitioners of homeopathic medicine or any of its regular organizations. The bill was introduced by Senator Mazingo of Darlington County and nothing contained in this article is intended to cast any reflection or criticism upon the Senator for his espousal of the cause. As a matter of fact, we have no idea that Senator Mazingo is aware of the implications of the proposed measure which he introduced.

The bill, which was referred to briefly in the February Newsletter, would if adopted, create a Board of Homeopathic Medical Examiners consisting of five, four of whom would be "physicians of homeopathic schooling and members in good standing of the South Carolina Homeopathic Council." The fifth member would be a medical doctor appointed by the Governor upon the recommendation of the State Board of Medical Examiners. All members would serve for a term of four years. The Board would be directed to hold two examinations a year on the following subjects: Anatomy, Physiology, Hygiene and Sanitation, Materia Medica and Therapeutics, Chemistry, Pediatrics, Urinalysis, Bacteriology, Pathology, Surgery, Principles of Practice, Obstetrics and Gynecology, "and any other subjects which the Board may deem necessary or advisable." The examinations would be "either written, oral, or practical laboratory or bedside examination or a combination of any of them."

Applicants would be required (1) to be not less than 21 years of age, (2) to exhibit a diploma conferring upon him the degree of Doctor of Medicine "from a legally chartered and reputable medical school or college recognized by the Board" and (3) also to produce certified credentials of preliminary education, and certificates as to moral character and sobriety by at least "two physicians acceptable to the Board," similar to those usually required in such cases. A deposit of \$25.00 as a license fee would also be requisite to taking the examination. Graduates of foreign medical schools would be admitted after meeting "such qualifications as the Board may reasonably require."

The simple reference to the educational qualifications required of applicants as quoted above from the bill, should be sufficient to indicate the nature of the

business proposed. The only evidence of professional education required is the presentation of a diploma conferring the degree of Doctor of Medicine from a legally chartered and reputable medical school or college recognized by the Board. The courses or the length of terms or hours of study are not even pretended to be indicated. Obviously, whether or not such school or college were "reputable" would be a matter for determination by the Board.

The South Carolina Homeopathic Council referred to in Section 1 of the Bill is not further defined. On December 7, 1951, however, a charter of the State of South Carolina was issued by the Secretary of State to the South Carolina Homeopathic Society. Its officers were Edward R. Huffman, president and treasurer, and William Schindeldecker, vice president and secretary.

Full information concerning the background and the obvious implications of the proposed bill is in the hands of the Legislative Committee of the South Carolina Medical Association. The Senate Committee on Medical Affairs, Hon. W. P. Baskin of Bishopville, Chairman, to which the bill was referred, has been requested to hold a hearing if, and prior to the time, any action is taken. The matter will be carefully watched but in view of the probable brief Session, there seems little likelihood that the proposed measure will make progress this year.

THE DOCTOR AND THE PRESS

The highly capable "Observer" of the *Medical Annals of the District of Columbia* so frequently expresses quotable views that we cannot resist the temptation to quote him fairly often. In the February issue of the *Annals*, in his department, "In and Out of Foes," there is an excellent treatment of the troublesome subject of doctors and the press. The following are the views expressed by Mr. Wiprud, Executive Secretary of the District's Medical Society, which we feel are highly worthy of passing on for the benefit of the members of the South Carolina Medical Association:

1. There is nothing as perishable as a newspaper 'story.' Yesterday's news is all but forgotten except by a small minority who because of some personal interest recall what "stood in the paper." There are too many world-shaking events for an ordinary incident to hold more than fleeting attention.

2. Nothing can be gained by keeping alive controversial issues unless they are of such momentous nature as to warrant it. Issuing statements or writing communications to the editor usually serve only to stimulate those who disagree to write more statements and communications.

3. There is no such thing as having 'our side' presented to the exclusion of those who do not agree with us. Most newspapers endeavor to present both sides of an issue, but complete objectivity is rare, human nature being what it is. Reporters, as your Observer has written previously, are influenced in what they write by their background, experience and

in arthritis
and allied disorders

BUTAZOLIDIN

(brand of phenylbutazone)



potent, non-hormonal antiarthritic agent

Its therapeutic effectiveness substantiated by more than fifty published reports, BUTAZOLIDIN has recently received the Seal of Acceptance of the Council on Pharmacy and Chemistry of the American Medical Association.

In the treatment of arthritis BUTAZOLIDIN produces prompt relief of pain. In many instances relief of pain is accompanied by diminution of swelling, resolution of inflammation and increased freedom and range of motion of the affected joints.

BUTAZOLIDIN is indicated in:

Gouty Arthritis	Rheumatoid Arthritis
Psoriatic Arthritis	Rheumatoid Spondylitis

Painful Shoulder (including peritendinitis, capsulitis, bursitis, and acute arthritis)

Since BUTAZOLIDIN is a potent agent, patients for therapy should be selected with care; dosage should be judiciously controlled; and the patient should be regularly observed so that treatment may be discontinued at the first sign of toxic reaction.

Physicians unfamiliar with the use of BUTAZOLIDIN are urged to send for complete descriptive literature before employing it.

BUTAZOLIDIN® (brand of phenylbutazone), coated tablets of 100 mg.



GEIGY PHARMACEUTICALS

Division of Geigy Chemical Corporation
220 Church Street, New York 13, N. Y.

In Canada: Geigy Pharmaceuticals, Montreal

360

troubles.

4. It should not be necessary to state that doctors or their medical organizations are not infallible. They make mistakes like everyone else. Some of them are news and a few make the headlines. When this occurs, physicians should submit to the inevitable with good grace.

5. Without wishing to minimize the influence of the press, causes are seldom won or lost because of individual or sporadic news articles. Some years ago, upon the suggestion of the Medical Society, a local newspaper began an investigation of a medical institution with the result that shortly thereafter very critical and highly provocative articles appeared, directing attention to the deplorable conditions which existed in the institution. Six months later your Observer learned that nothing had been done to correct the situation, so he called it to the attention of the newspaper, which again published a series of excoriating articles. Under these circumstances one would think that public indignation would be such that something would be done; but the situation remained as it was for several months thereafter. Even today conditions at this institution are not what they should be.

Long and persistent effort is required to remedy as bad a situation as this was, including the wholehearted and continuous support of one or more newspapers.

In the light of these observations, what should individual physicians and medical organizations do to obtain generally favorable treatment by the press? Here are a few suggestions:

1. They should see to it that the press has knowledge of all constructive efforts made by the medical profession to protect and improve the public health.

2. Where there are injustices, they should see to it that their 'story' is told at the proper time. Negativism, however, can only lead to public disapproval and an unfriendly press.

3. Wherever and whenever conditions warrant, officials of medical organizations should discuss frankly with press representatives the problems facing the profession. Under proper circumstances, this can also be done by individual physicians. In either instance, it may be desirable to do so for the purpose of pro-

viding background information only and not with a view of being quoted or credited with supplying the information.

While it is what medical organizations do and not what they say which counts most, it is important that they say what they have to say at the proper time. It is as simple as that!

FOR SALE: Eye, Ear, Nose and Throat instruments. Fifty percent (50%) of list price. Some practically new including Maico Audiometer. Dr. J. T. Carter, 16 Woodburn Road, Spartanburg, S. C. Telephone 3-5782.

WANTED: Anesthesiologist (M.D.) desires change. Private fee basis only. Experienced in all types of anesthesiology. South Carolina native and resident. For information write Journal of the S. C. Medical Association, Florence, S. C.

DOCTOR WANTED: Progressive small town, population 565 persons, has a very attractive proposition for practice of General Medicine. New, modern home and office will be available. Contact H. E. Kirven, Pinewood, S. C., immediately by telephone, or write for particulars.

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

Stone Mountain Sanitarium operating as **STONE MOUNTAIN MANOR** **STONE MOUNTAIN, GEORGIA** (Suburban Atlanta)

For the treatment of Psychiatric illness and addictions. Analytically oriented Psychotherapy — Recreational Therapy — Electric Shock. Custodial care for seniles.

Phone—Stone Mountain 2511
Atlanta Office—803 Medical Arts Building
(Phone—ALpine 5848)

W. E. Burdine, M. D. — Medical Director
Vernelle Fox, M. D. — Chief of Geriatric Service
Roy M. Mundorff—Administrator Myron Weiner, A. B., M. B., Psychologist

The Journal

of the

South Carolina Medical Association

VOLUME L

April, 1954

NUMBER 4

Vertigo and Dizziness - From the Viewpoint of the Internist

VINCE MOSELEY, M. D.*

Dizziness is a common and confusing complaint. There are many synonyms for this condition which vary in meaning when the word is used to describe a chief complaint and the range of meaning in common usage varies from that of aural vertigo to that of irresponsible behavior, (e. g., "a dizzy blonde.") As a subjective symptom "giddiness," "drunk headed," "swimming in the head," "black out feelings," "unsteadiness," and "head swinging," are frequently employed terms which may indicate vertigo or syncopal-like sensations. As a consequence, great care must be taken and a painstaking attempt be made to try to have the patient describe in complete detail the entire gamut of subjective sensations experienced when the complaint is dizziness or some variant similar expression. Is it true "vertigo?" i. e.: is the patient subjectively whirling in space, or is the environment moving around him? Or, is it "dizziness?" For purposes of this paper, I shall purposefully and arbitrarily define "dizziness" as not being synonymous with "vertigo," but a symptom *akin*, yet distinctly different, in that there is no sense of whirling in space, or vice versa, but instead there is with this complaint a sense of motion or unsteadiness within the head with oftentimes subjective diminution of the acuity of visual and auditory preception; often accompanied by a dulling, slowing, or confusion of the thought processes. (See Table I).

If we can establish that the patient is complaining of true "vertigo" the problem is often much simpler than when we are confronted

with the fact that only "dizziness" can be comprehended as the complaint, for then we have to consider not only the disease processes which may cause true vertigo, (in a mild or abortive form), but also all of those which may cause central vertigo and dizziness (See Table I, paragraphs A & B).

In the succeeding sections of this paper, I shall try to present my ideas and method of approach to this difficult symptom complex, utilizing the outline of Table I to present from a purely clinical standpoint the differential points that are to be learned from the history and from the bedside or office observation of a patient, utilizing the ordinary generally applicable methods of patient examination. Other papers being presented by various especially qualified members of this panel will present a discussion of the various types of more specialized examinations that may be needed in a given patient for final definitive diagnosis. Therapy is not discussed.

In taking the history we must know:

1. The exact subjective sensations experienced.
2. The manner of onset and duration.
3. Severity of symptoms and residual symptoms.
4. Associated symptoms, such as nausea, vomiting, diarrhea, tinnitus, deafness, loss of consciousness, or extreme hebetude, visual difficulties, convulsions, headaches, weakness of extremities, fever, or allergic manifestations.
5. The influence of posture.
6. Recent use of any drugs or exposure to toxic agents, chemicals, or gases.
7. State of health in general.

* Department of Medicine, Medical College of South Carolina, Charleston.

TABLE 1

VERTIGO	VS	DIZZINESS
(Subjective whirling in space; either as turning in environment or as environment turning about self)		(Subjective sense of unsteadiness without sensation of environment change with dulling of perception and thought processes, mild syn- copal type symptoms)
A—Peripheral (Labyrinthine)		A—Specific Cerebral Lesions Mild as with central vertigo causes. (see paragraph C of Vertigo)
1. Acute; brief—"Meniere's syndrome."		B—General Cerebral Causes—not specific localized lesion
2. Acute; of long duration Labyrinthine injury—toxic—infectious— vascular—trauma.		1. Increased intracranial pressure of any etiology.
B—Motion Sickness		2. Derangements of general cerebral func- tion (related to syncope).
C—Central (Localized lesions-retro-labyrin- thine)		a) Anoxia—(anoxic and anoxemic). (1) Vascular. (2) Cardiac. (3) Pul- monary. (4) Hypertension. (5) Hypo- tension. (6) Anemia. (7) Abnormal hemoglobin. (8) Stasis of blood flow.
1. Acute—Vascular (Posterior inferior cerebellar artery syndrome)		b) Electrolyte Imbalance $\begin{matrix} ++ & - & + \\ (Ca, Cl, K, \\ + \\ Na). \end{matrix}$
2. Chronic—Expanding lesions as from tumors, cysts, granulomas. Vascular stasis. Multiple sclerosis. Brun's syndrome.		c) Metabolic (hypoglycemia, etc.) d) Endocrine (Addison's disease, etc.) e) Fever—Infection. f) Post-traumatic. g) Psychogenic.

VERTIGO

If we can establish the fact that our patient is describing to us "true vertigo," then our next step is to determine if it is paroxysmal, of brief duration, recurrent, and whether accompanied by deafness, tinnitus, nausea, and vomiting; nystagmus should be observed in an attack. If so, then Meniere's syndrome is quickly established as the tentative correct diagnosis. If the patient is seen during the first attack one must wait and observe the duration of the episode. If of more than several hours duration a variety of other conditions must be considered, such as acute epidemic labyrinthitis (an influenza-like illness), the labyrinthitis of viral hepatitis, or specific infections, such as syphilis. Purulent mastoiditis may often be responsible and an examination of the ears and mastoid areas is essential.

Toxic vertigo, as from quinine, neomycin, or streptomycin, may simulate in all details the Meniere's symptom complex except that the vertigo is usually not sudden but gradual in onset and chronic. Our chief interest here is to recognize this possibility from our history and to differentiate toxic vertigo from the infectious forms that will be discussed later under "central vertigo." Salicylates, triodine, and dilantin are drugs in addition to those

previously mentioned which are most frequently the offenders in this regard. Alcohol, excessive tobacco smoking, and chronic carbon monoxide poisoning are also causes of toxic vertigo which may be overlooked though these are not in the scheme of Table I as examples of peripheral vertigo, but are causes of "central vertigo."

Motion sickness usually is readily recognized and needs no further comment at this time.

Vascular lesions are frequent causes of central vertigo. Infarctions involving the retro-labyrinthine structures or vestibular nuclei of the brain stem produce sudden and severe vertigo. Posterior inferior cerebellar artery thrombosis frequently has as a presenting complaint sudden, severe and lasting vertigo with nausea, vomiting, and nystagmus. The involvement of other brain stem structures in this and other instances of sudden occlusions of the other short arteries, supplying the brain stem, will be accompanied by additional symptoms and signs arising from derangement of function of such adjacent structures as the 5th nerve nucleus, spinothalamic tracts and pyramidal tracts. The proper diagnosis is usually obvious after even a cursory neurological examination; looking particularly for evidences of other cranial nerve involvement and ex-

tremity paresis of the crossed type.

Tuberculous basilar meningitis, arachnoiditis, torula infection, meningo-vascular syphilis, and encephalitis involving the brain stem should be suspected because of the slower manner of onset and extreme chronicity of the symptoms. There are also often obvious signs of meningeal irritation to be observed in these patients.

Cerebellar-pontine-angle tumors may produce chronic vertigo and deafness. These will be suspected because of the chronicity and absence of acute or paroxysmal characteristics. Various neurological signs are usually discernible in these instances; loss of the corneal reflex especially on the involved side should be tested for.

Other brain stem tumors, such as the relatively rare "4th ventricle tumors" may be a cause of confusion. The so called "Brun's syndrome," originally described in a patient with a granuloma "tumor" partially obstructing the 4th ventricle, produces intermittent and paroxysmal vertigo mimicking the Meniere's syndrome, except for the lack of tinnitus and deafness. The vertigo attacks are produced by sudden changes in posture. Here it must be recalled also that turning to the affected side often makes labyrinthine vertigo worse, but in addition the "Brun's syndrome" is usually also accompanied by rather severe headache, a rise in blood pressure and retinal edema or other evidences of intermittently increased intraventricular pressure.

Intracranial tumors at certain sites other than the brain stem area may also produce vertigo. Those involving the cerebellum, sylvian fissure area, and temporal lobe area are the ones most often reported as producing true central type vertigo. The central sensory area for appreciating spatial relationship is located in this part of the cerebrum. Vertigo is generally a symptom of a minor degree of prominence with brain tumors in other sites and usually is over-shadowed or preceded by other symptoms and neurological signs. In these instances tinnitus and deafness are usually conspicuously absent.

Multiple sclerosis is the most difficult neurological lesion to differentiate as a cause of vertigo, from one of the peripheral causes of

aural vertigo. Here close attention to the details of the neurological examination and a study of the spinal fluid will have to be resorted to.

Epileptic equivalents may prove very difficult at times and may require the help of the electroencephalogram.

Migraine may often be associated with features similar to those of the Meniere's syndrome. The lack of deafness, absence of tinnitus, prominence of headache, and the prompt response to ergotamine tartrate are diagnostic clues.

Sickle cell anemia, leukemia, purpura, and embolic episodes as from subacute bacterial endocarditis may produce small infarctions in the brain stem with vertigo as a sudden severe and single symptom. Here the careful general evaluation of the patient will provide the essential criteria for correct diagnosis. A complete physical examination is essential in these, as in all cases.

DIZZINESS

Dizziness as a symptom in the terms previously defined is closely related to syncope and one of the earliest manifestations of impending syncope is the subjective group of sensations enumerated. If this is the symptom complex one believes that the patient is describing, one will have to consider not only the several causes of true vertigo (central type) as previously outlined but in addition a great number of possible additional causes. It is extremely important to try to determine the subjective sensations as experienced and remembered by the patient, as to whether it is vertigo or dizziness, but one must not assume that if it is "dizziness," that this automatically rules out the processes that have been enumerated as causing vertigo. In some individuals stimuli such as those produced by caloric testing or whirling in a Barany chair never cause anything more than a subjective sense of lightheadedness or emptyheadedness, whereas, in others prostrating vertigo with all the accompanying vasomotor phenomena are quickly produced; so that it is impossible to be as certain with dizziness as it is with the clear cut symptom of vertigo as to what one is probably dealing with.

With dizziness one should inquire and look

for evidences of cardiovascular disease, such as hypertension, cerebral arteriosclerosis, hyperactive carotid sinus reflex, and cardiac arrhythmias, particularly paroxysmal auricular fibrillation and tachycardia, ventricular tachycardia and Stokes-Adams syndrome with heart block.

Paroxysmal hypertension as from pheochromocytoma is often accompanied by sudden dizzy spells along with palpitation.

Postural hypotension must not be overlooked and blood pressure recordings when erect and recumbent must be made routinely. Myasthenia gravis in this regard must be remembered as one of the conditions in which postural hypotension is observed. The pathogenesis of dizziness in the cardiovascular disorders mentioned appears to be the same in all instances; viz., decreased cerebral blood flow with subsequent anoxia.

Increased venous pressure with stasis of the cerebral circulation may also produce dizziness. Examples of this are to be found in occlusion of the superior vena cava and in pulmonary disease with cor pulmonale secondary to pulmonary arterial hypertension. Laryngeal spasm, tracheal obstruction, and severe paroxysmal coughing may cause a marked rise in the jugular venous pressure and similarly produce a slowing of the cerebral blood flow by the back pressure mechanism previously described and by also lowering cardiac output.

Anoxia from anemia or from abnormal hemoglobin as from various poisons or drugs is a cause for chronic dizziness. As examples we may cite nitrites, sulfates, sulfonamides, acetanilid and carbon monoxide as substances producing abnormal hemoglobin combinations resulting in cerebral anoxia.

Stasis of blood flow in the cerebral circulation from various factors producing increased blood viscosity, as in polycythemia vera, leukemia, and sickle cell anemia must also be remembered in relation to the symptom of dizziness.

Patients with deranged metabolic functions, such as hypocalcemia and hypoglycemia are not infrequently seen with the chief complaint of recurring dizziness. Likewise endocrine diseases or dysfunctions cause dizziness. This is more commonly observed in relationship to

Addison's disease and ovarian disease, particularly the failing ovary of the menopause period.

In certain of the "B complex" vitamin deficiency states dizziness is a prominent complaint. As examples, and most commonly recognized in this regard, are to be cited pellagra, beri beri, and pernicious anemia.

Vaso-vagal episodes producing a fall in blood pressure and a reduction in cerebral blood flow may be initiated by any number of factors and just as when in the course of undue stimulation of the labyrinthine and vestibular structures one observes simultaneously the initiation of a number of vasomotor reactions which result in the signs of pallor, sweating, nausea, vomiting, and diarrhea, so it is observed that under many different circumstances when these reactions are induced by local or systemic alterations of the gastrointestinal tract, dizziness may result. As examples to be cited are the episodes of dizziness which occur frequently in association with any number of severely painful experiences, as with gall bladder attacks or spasm episodes associated with the irritable colon syndrome.

Dizziness is often complained of in the acute infectious diseases as a part of the prodromal symptoms. As examples, one may cite infections hepatitis, influenza and malaria.

Asthenia, headache and dizziness in the housewife should always bring to mind chronic carbon monoxide poisoning, as well as psychoneurosis and menopause (probably our most frequently overworked explanations).

Motion sickness may be a cause for continuing and recurring dizziness. In adults the patient can usually recognize the clear cut relationship. In children it may at times be puzzling but usually not in relationship to vertigo or dizziness as the complaint but as recurring nausea, pallor, weakness and sweating in the child.

As a part of the general systemic response to some allergenic substances dizziness is often observed. This is distinct and separate from the statement by some that Meniere's syndrome may be due specifically to allergic edema of the labyrinth.

As a sequel of trauma to the head or neck, dizziness is a common and distressing symp-

tom to try to evaluate adequately and to treat.

Visual defects and extraocular muscle imbalance must be looked for in the chronic recurring instances of dizziness and headache or nausea.

Last, but not the least, from the standpoint of frequency of diagnosis is the observation as to the frequency of dizziness as a complaint in individuals who are extremely anxious, or confronted with problems that cause chronic apprehension. Overbreathing is often exhibited by these individuals. The hyperventilation syndrome should always be thought of in this regard and deliberate maneuvers to produce hyperventilation should be carried out, when it is suspected that this is the cause of the symptoms. Often with only this single demonstration and with an explanation of its meaning to the patient a most satisfactory therapeutic response will result.

SUMMARY

Vertigo—a subjective sensation of whirling by the patient in relationship to his environment—is a symptom which usually points to a

definite derangement of the pathway of equilibratory sense. The site may be peripheral in the labyrinth or retrograde to this in the nervous connection between this organ, the vestibular nuclei, interconnected nerve pathways, or the central site for sensory localization of spatial orientation.

Dizziness may be a variant of vertigo in minor degree but is more often a symptom produced by a state of general cerebral dysfunction such as may occur in situations related to anoxia, cerebral blood stasis, or metabolic derangement.

A careful history and complete physical examination, including attention to the neurological examination, is necessary in all instances to arrive at a proper diagnosis. Often additional aid from various qualified specialists will be needed to establish the exact anatomical site involved and etiological agent responsible.

[This paper is part of a symposium on Vertigo and Dizziness. Others will follow in later issues.—Ed.]

Pancreatico-Duodenectomy for Carcinoma of the Ampulla of Vater

A CASE REPORT

HENRY W. MAYO, JR., M. D.

Prior to the development by Whipple,⁶ in 1935, of the two-stage radical pancreaticoduodenectomy for carcinomas arising in the head of the pancreas, ampulla of Vater, distal common duct, and duodenum, these lesions were considered to be hopeless, and all efforts were directed toward achieving palliation. This method of treatment has been found to be technically feasible, and, with the introduction of gastric suction, antibiotics, and other surgical adjuvants, such procedures have been carried out in one stage in recent years.⁷ The purpose of this paper is to review briefly the characteristics of ampullary car-

cinoma as seen by the clinician, and to present a report of such a case, illustrating the method of management.

The presenting symptom of carcinoma of the ampulla of Vater is usually jaundice of the obstructive variety. It is not within the province of this paper to discuss the differential diagnosis of jaundice, but once it is reasonably well established that the jaundice is of an obstructive nature, and not on the basis of hepatitis, exploration is indicated. The jaundice of carcinoma of the pancreatic head is likely to be unremitting, but the degree of jaundice may fluctuate considerably, if due to carcinoma of the ampulla, because of temporary relief of obstruction when the central portion of the tumor sloughs out. As in cases of carcinoma of the head of the pancreas, Courvoisier's law will hold true in most instances, since the back pressure created by the

From the Department of Surgery, Medical College of South Carolina, and the Roper Hospital, Charleston, South Carolina.

Presented at the Annual Meeting of the South Carolina Chapter, American College of Surgeons, October 20, 1953, Charleston, South Carolina.

lesion obstructing the common bile duct will cause dilatation of a non-inflamed gallbladder, thus making the enlarged gallbladder palpable to the examining hand. Like carcinoma of the head of the pancreas, a malignant lesion of the ampulla is most commonly found in patients between the ages of 40 and 60, and is more common in men than in women. While pain may be present in some cases of carcinoma of the head of the pancreas before jaundice appears, pain of a colicky nature, simulating the pain associated with common duct stone, is sometimes noted in cases of ampullary carcinoma. Cholangitis, manifested by recurrent chills and fever, is frequently seen in association with carcinoma of the ampulla, but practically never in association with carcinoma of the head of the pancreas. According to Cattell and Warren,² weight loss, fatigue, and anemia are commonly associated with both of these conditions. Cooper⁴ noted that 82 percent of cases of carcinoma of the ampulla of Vater were found to have occult blood in the stools.

To date, confirmatory diagnostic procedures have been of little value. However, the drainage of duodenal contents by an inlying tube, and examination of the material so obtained by the Papanicolaou technique appears to be promising, and recent reports⁶ have appeared illustrating the success of this method. In many early cases of carcinoma of the ampulla of Vater, or carcinoma of the head of the pancreas, radiologic maneuvers are of no value, but in the latter cases, one may note a widened duodenal loop, an "inverted 3" sign at the ampulla, obstruction of the duodenum, diminution of peristaltic activity along the medial border of the duodenum, or demonstration of a definite ulcerative lesion or filling defect on the medial border of the duodenum. Cholecystography appears to be of little value, but with the use of oral "telepaque," the common bile duct may occasionally be visualized by this maneuver, and, if so, some idea concerning the location and characteristics of the lesion may be gained.

Preoperative preparation, as in any case of gastrointestinal disease, is concerned with correction of such deficits as hypoprothrombinemia, hypoproteinemia, anemia, and dehydra-

tion. Antibiotics are administered if there is any clinical evidence of cholangitis.

At operation, in most cases of carcinoma of the head of the pancreas, the lesion is not found to be subject to resection because of invasion of the superior mesenteric vessels or of the portal vein. Recently Child and others³ have successfully resected the portal vein, both in the monkey and man, by utilization of a two stage procedure, and this method may increase the possibility of resection in carcinoma of the head of the pancreas. Such extension is not nearly so common in the case of carcinoma of the ampulla of Vater, and consequently, the majority of these lesions should be amenable to resection by the one stage Whipple technique, a variant of which is described in the case report below. Obviously, when distant metastases are present, or when there is local invasion beyond the confines of possible resection, attempts at curative surgery are contra-indicated. In such instances, cholecystojejunostomy, either by the Roux-en-Y technique, or using a loop of jejunum with the addition of an entero-enterostomy, will give some degree of palliation, relieving the jaundice, and to some extent relieving the pain. Pain relief may be increased by celiac ganglionectomy or splanchnicotomy.

Unfortunately, radical pancreaticoduodenectomy has not proven to be a curative procedure in the case of carcinoma in the head of the pancreas. To date, there are only four or five such cases reported as five year survivals. Nevertheless, with earlier diagnosis and a more aggressive approach to the patient with obstructive jaundice, it is still possible that these results may be improved. On the other hand, on the basis of various statistics quoted by Cattell and Warren,^{1,2} one would expect a respectable salvage rate after pancreaticoduodenectomy for carcinoma of the ampulla of Vater. Thus, at the Lahey Clinic, 11 of 28 patients surviving this operation lived three years or more, and three of ten patients operated on more than five years ago are living and well.

The mortality rate of an operation of such magnitude is necessarily rather high, and in the hands of authorities reporting on the subject has been in the neighborhood of 25%.

Many of the operative deaths have been on the basis of biliary and pancreatic fistulas, and with improvement in the technique of the necessary anastomoses, such failures should be less common. Complications of such operations include the usual surgical complications, and in addition biliary fistula, pancreatic fistula, mild diabetes mellitus, and marginal (jejunal) ulcer. Most of these complications can be satisfactorily handled with conservative treatment.

With regard to diagnosis at the time of operation, if a lesion is palpable in the region of the ampulla of Vater, one may wish to open the duodenum and remove a portion of the lesion, awaiting frozen section before proceeding with a radical operation. While such a procedure would be desirable in such cases where the nature of the gross pathology appears to be questionable, in many cases the characteristics of the lesion will suggest obvious carcinoma to the surgeon versed in gross pathology, and in such instances contamination of the operative field by cancer cells may be avoided by elimination of preliminary biopsy. Biopsy of pancreatic lesions presents an even more difficult problem, because carcinomas are frequently surrounded by a zone of pancreatitis, and because deep biopsy of the pancreas in itself is not an innocuous procedure, frequently resulting in alarming hemorrhage or pancreatic fistula. The Silver man needle, as described by Kirtland,⁵ should prove useful for such pancreatic biopsies, but in some cases it will be necessary for the operator to seize the only available opportunity for salvage of the patient, despite his inability to readily obtain a positive report, and to carry out the radical procedure.

Case Report: Mrs. J. L., a 69 year old white female housewife, was admitted on March 10, 1953 because of jaundice of four days' duration. She had not felt well for three months preceding admission, and during that time she had lost about 13 pounds. She had had occasional nausea, but no pain, and had vomited only once on the day preceding admission. The color of her stools was unknown, but there had been no change in her bowel habits. However, she had noticed dark urine for one week preceding admission. There was no history of hematemesis, but she had had "heart-burn" for several months. For several years she had had frequent headaches which were usually relieved by aspirin. During the two days before admission she had noted pruritus and for four days before admission she had noted that her skin and sclerae were jaundiced. Her past history, family history and review of systems elicited no significant information.

On physical examination, her temperature was 102° and pulse 88. She was an elderly white female with definite evidence of weight loss. Her skin and sclerae were icteric, and her mucous membranes pale. She was edentulous and wore upper and lower plates. A grade II systolic murmur was audible, being heard best over the aortic area. Her blood pressure was 190/100. Her liver was palpable 6 cms. below the right costal margin, and one observer thought that he felt an indefinite cystic mass below the edge of the liver on the right.

The red cell count was 2.5 million, hemoglobin 6 gms., WBC 13,300, with 80 percent PMN's, 12 non-filamented, 19 lymphocytes, and 1 monocyte. The urine was negative except for a 1+ albumen. The urine was positive for urobilinogen in a 1-5 dilution. Her BUN was 15 mgms. per 100 cc, blood sugar 103 mgms. per 100 cc, alkaline phosphatase 27.3 Bodansky units and serum proteins 8.57 gms. per 100 cc with 3.04 gms. of Gamma Globulin. Her serum bilirubin was 3.7 mgm. per 100 cc, prothrombin time 100%, cephalin flocculation 1+, and her stools were negative for changed bile, but the test for occult blood was reported as 4+.

X-ray of the chest was essentially negative except for slight left ventricular hypertrophy. A barium enema was negative. About a month previously, she had had a complete gastrointestinal x-ray series elsewhere which was reported as negative, and at that time a gallbladder series was said to show a non-functioning gallbladder.

During the first few days of hospitalization, her temperature ranged from a normal level in the morning to between 101° and 103° in the evening. It was thought that this spiking fever was due to cholangitis, which was treated empirically with streptomycin and penicillin. After the sixth hospital day her temperature remained normal until the time of operation. She was given daily transfusions of 500 cc. of blood, and after 2,000 cc. of blood had been administered, her red cell count was recorded as 4.02 million, and her hemoglobin as 12 Gms. Her headaches became a little more pronounced, but not particularly localized to any portion of the cranium.

On March 19, 1953, under general endotracheal anesthesia, the upper portion of her abdomen was explored through an upper right subcostal incision. When it was found that the lesion was operable, this was extended to create a transverse incision all the way across the upper abdomen. At operation all the tissues were jaundiced. The liver was slightly enlarged, but it was of normal color, and no nodules were noted in it. The edges of the liver were sharp. The gallbladder was tremendously distended, and its wall somewhat thickened, but there were no stones in the gallbladder. Both hepatic ducts were markedly dilated. In the region of the ampulla of Vater there was a stony-hard ulcerative lesion palpable, which was about 3 cm. in diameter, and which was freely movable. The edges were raised and were particularly hard. Several enlarged nodes were noted in the region of the head and body of the pancreas. The largest of these was removed and sent for frozen section, and was reported as showing no evidence of malignancy. Further exploration of the remainder of the abdomen was entirely negative for metastases or other evidence of disease. Figure 1 illustrates the operative findings and the procedure carried out. The peritoneum lateral to the duodenum was incised, and this incision carried around the lateral margin of the duodenum so that the entire duodenum was freed, and then the ligament of Treitz was divided and the duodenum was freed from its attachments to the transverse mesocolon. The gastro-hepatic ligament was then divided between clamps and ligated and this division extended up to a point just proximal to the pylorus. In

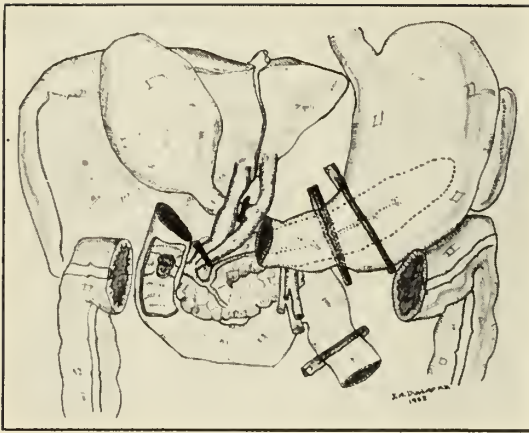


FIGURE I

Operative findings. The clamps indicated the points at which the pancreas, stomach, jejunum, and bile ducts were divided.

like manner, the vascular pedicles of the gastro-colic ligament were divided and ligated. The stomach was then transected between clamps at a point 4 cm. proximal to the pylorus. The jejunum was divided at a point just distal to the ligament of Treitz, and the distal portion of the duodenum drawn through the rent in the transverse mesocolon and beneath the superior mesenteric vessels. The body of the pancreas was then freed posteriorly from the portal vein, and in this process, one branch of the portal vein was torn with resulting moderate hemorrhage, which was controlled with packing. Later, after the portal vein was cleared, the branch which was bleeding was isolated and identified, clamped and ligated. The gastro-duodenal artery was dissected out, and ligated. In like manner, the inferior pancreaticoduodenal artery was divided between clamps and ligated. Various venous branches of the portal vein passing into the pancreas were divided between clamps and ligated. It was then possible to free the uncinate process from the inferior surface of the superior mesenteric vessels and draw it out. In this way the specimen was now free except for its pancreatic attachment and for the hepatic ducts. The pancreas was then severed transversely in the mid-portion of the body and the pancreatic duct identified, but not ligated. What was thought to be the common bile duct was then transected and the specimen removed. It then became apparent that the duct had two lumina and in an effort to determine the anomalous situation of the bile ducts, it was necessary to remove the gallbladder from above downward in the usual manner, ligating and dividing the cystic artery. The cystic duct was very long and passed behind the right hepatic duct, emptying into the left hepatic duct. The cystic duct was ligated and divided, leaving a remnant of cystic duct about 1 cm. long. It then became obvious that the two lumina were those of the two hepatic ducts which were fused together with a thin septum in between. This septum was divided for a distance of about 3 cm., thus converting the distal portion of these ducts into one lumen. The stump of the pancreas was embedded in the distal end of the jejunum, which had been drawn through the rent in the transverse mesocolon, this being accomplished with two rows of interrupted cotton sutures so that the serosal surface of the bowel was in contact with the external surface of the pancreas at all points. About 10 cm. distal to this point, an anastomosis was created between the hepatic ducts and the jejunum,

using an inner layer of chromic 00 atraumatic (Connell) catgut, and an outer layer of interrupted cotton. No tube was used in this anastomosis. About 40 cm. distal to the pancreatico-jejunal anastomosis, a gastro-jejunostomy was performed end-to-side, using again an inner layer of chromic 00 (Connell) catgut, and an outer layer of interrupted cotton. The edges of the rent in the transverse mesocolon were then fixed to the jejunum and its mesentery so as to avoid internal hernia. A drain was placed in the region of the tail of the pancreas and brought out through a stab wound in the left side of the abdomen, and another drain placed in the region of the gallbladder bed and brought out through the right side of the abdomen through another stab wound. The abdomen was then closed in layers with a continuous suture of chromic 0 catgut for the peritoneum and posterior rectus sheath, interrupted #40 cotton for the anterior rectus sheath, and interrupted fine cotton for the subcutaneous tissue and skin. The patient stood the procedure remarkably well. During the procedure she received four pints of blood. She returned to the ward in excellent condition. The plan of surgical reconstruction is illustrated in Figure II.

The pathology report was as follows: "A 21 cm. segment of small intestine, one end apparently being the pylorus and attached portions of pancreas. At a point 8.5 cm. distal to the pylorus, the mucosa of the duodenum is interrupted by a raised ulcerating tumor mass measuring 2.5 cm. into which the common bile duct and the pancreatic duct empty through separate openings, separated by a distance of .5 cm. The right and left hepatic ducts join 2.5 cm. proximal to the opening of the common duct, and the common duct is dilated, measuring 4 cm. in circumference with this dilatation also being reflected in three hepatic ducts. In separate container, a gallbladder measuring 14 cm. in length and having a moderately thickened wall. (Figure III illustrates the gross specimen removed at operation.) Attached to the duodenum specimen are portions of mesentery containing several small lymph nodes measuring up to .6 cm."

The gallbladder wall shows active chronic inflammatory reaction with similar active chronic inflammatory changes of the common bile duct. Sections of the pancreatic duct show dilatation but only minor inflammatory involvement. The pancreas shows no significant changes. Sections of the duodenum show mucosal ulceration and sub-surface infiltration of malignant gland-forming epithelial cells, which apparently originate in the ampulla of Vater. Also sections of lymph nodes which show no significant changes."

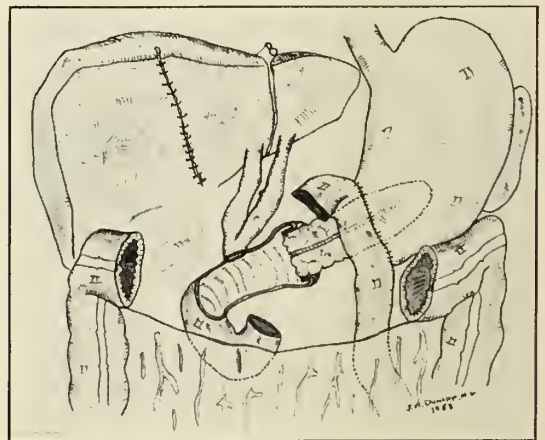


FIGURE II

Method of operative reconstruction.

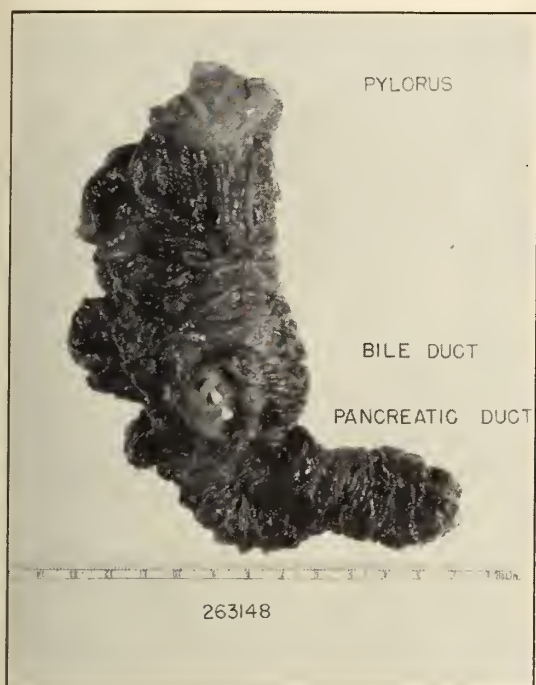


FIGURE III

Gross specimen. The two probes are in the bile and pancreatic ducts respectively.

The pathologic diagnosis (Dr. E. E. McKee) was "carcinoma of ampulla of Vater, with obstruction of common bile duct and pancreatic duct; chronic cholecystitis; pancreas, portion of; lymph node from abdomen."

Postoperatively, the patient had a remarkably smooth course, the highest temperature recorded in the postoperative period being 99.6°. There was a moderate amount of serous drainage from the drain sites, and at one time this was tinged with bile. Bile returned through the gastric suction tube on the first postoperative day. On the day of operation, hemoglobin was noted in the urine, and it was thought that she had had a mild hemolytic reaction to transfusion. Her icterus index rose during the first several days

after operation and then fell abruptly. At the time of discharge, her serum bilirubin was 1.6 mgm. %, but shortly after discharge she showed no sign of jaundice at all. Her gastric suction tube was removed on the fourth postoperative day and the patient was out of bed on the same day. Stools postoperatively were consistently positive for changed bile. The patient complained bitterly in the postoperative period of pancreatic headaches. Skull films were taken, and these were negative except for the presence of hyperostosis frontalis interna. An electroencephalogram was negative, and a spinal puncture revealed that the spinal fluid was negative both as regards dynamics and as regards content. The patient was discharged in good condition on her 13th postoperative day. Six weeks after her discharge she was still in excellent condition, although she still complained of headache, but of diminished intensity. Eleven months after operation her physical condition was excellent, but signs of mental deterioration and senile paranoia were quite apparent.

Summary: The clinical characteristics of carcinoma of the ampulla of Vater have been presented with an illustrative case report.

REFERENCES

1. Cattell, R. B., and Pyrtek, L. J.: Appraisal of Pancreatico-Duodenal Resection; Follow-up Study of 61 Cases. *Ann. Surg.* 129: 840-849, 1949.
2. Cattell, R. B., and Warren, K. W.: *Surgery of the Pancreas*, Philadelphia, W. B. Saunders Co., 1953.
3. Child, C. G., Holswade, C. R., McClure, R. D., Gore, A. L., and O'Neill, E. A.: Pancreatico-Duodenectomy with resection of the Portal Vein in the Macaca Mulatta Monkey and in Man. *Surg., Gyn., and Obst.*, 94:31-45, 1952.
4. Cooper, W. A.: Carcinoma of Ampulla of Vater. *Ann. Surg.* 106: 1009-1034, 1937.
5. Kirtland, H. B., Jr.: A Safe Method of Pancreatic Biopsy. *Am. J. Surg.* 82: 451-457, 1951.
6. McNeer, G. and Ewing, J. H.: Exfoliated Pancreatic Cancer Cells in Duodenal Drainage; A Case Report, *Cancer* 2: 643-645, 1949.
7. Whipple, A. O.: Observations on Radical Surgery for Lesions of the Pancreas, *Surg. Gyn., and Obst.* 82: 623-631, 1946.
8. Whipple, A. O., Parsons, W. B., and Mullins, C. R.: Treatment of Carcinoma of the Ampulla of Vater. *Ann. Surg.* 102: 763-779, 1935.

"Did you ever try to put yourself in the place of a sensitive sick man going to a large hospital? I have, and I've come to see that the experience may be very hard. It was far worse before we had the help of Social Service workers. Of course all these trials against which sensitive persons protest are perhaps inevitable; but certainly a sick man on going to a hospital has a right to demand better treatment than he gets from the ticket-agents and gatemen in a railway station. Of course, too, all officials who deal personally with the great public must have a hard time of it. Every policeman knows that. That great public is rude, boisterous, and uncivil mostly,—on the street, on its travels, and at baseball games. In such places it needs firm, and even rough handling. But when the great public is ill and

goes to a hospital, it must be kindly treated. Then it is frightened; it is in pain; it has fever; it is mystified; it is not bossing its own job, it is confiding itself to the care of strangers, whom it is told to trust, and it feels that it is entering blindly upon a great, strange and terrible experience. We doctors, in talking to a poor patient in our offices, and when advising his going to a general hospital, are often unreasonably impatient and irritable because the patient shrinks from the prospect. I'm afraid we're sometimes sumptuous and patronizing. Our point of view seems often to be that we alone are bestowing the benefit,—a mediaeval and absurd notion."

James G. Mumford

"A Doctor's Table Talk" 1912

Pediatrics - Then and Now

CHANGES DURING THIRTY YEARS IN INCIDENCE AND MORTALITY OF DISEASES IN SOUTH CAROLINA AND THE UNITED STATES*

RICHARD M. POLLITZER, M. D.

Greenville, South Carolina

All of us well know that the parading of many statistics can become very tiresome and at times proves little. Further some statistics can even be misleading, but in general if the figures are carefully collected from reliable sources, in sufficient amount and then analyzed without attempting to make them fit into some preconceived theory one may be able to make deductions.

The figures used here are believed to come from reliable sources. Also while not in excessive amount, they are thought to be adequate. This too may be said of the time element. Even though thirty years is not sufficient in archeological or geological discussions, yet in social science some history, and as a rule in medical history, it is a period worthy of consideration and one in which marked changes may occur.

The art and the science of medicine as we know it today has been tremendously influenced by the contributions of many eminent men of the past. Within the last four centuries vast changes have occurred in the theory and the practice of medicine. Few of us realize how much we are indebted to Paracelsus, Paré, Vesalius, Harvey, Sydenham, John Hunter and many others. The advances made by Pasteur and Koch are just as striking. From the turn of the century progress in medical science has been amazing.

All who have been practicing medicine during the past thirty years or who have read some of the medical literature of that period must have been impressed with the changes in the morbidity and mortality in general, and in certain diseases, particularly in children. Immediately one wonders what population changes have occurred. The facts are the population of U. S. in 1920 was 105,710,620 and in 1950 it was, 156,697,361 which is an increase of about 50 million in 30 years. The population

of S. C. in 1920 was 1,683,724 and in 1950 it reached 2,117,027, making an increase in this state during those thirty years of approximately one-half million.

Let us briefly consider the changes that have come about in the frequency of certain specific diseases within the last 30 years. In this state, in most localities, there were many cases of typhoid and deaths were not uncommon. Figures for deaths from typhoid in S. C. in 1920 were 64 and in 1950, none, in the U. S. in 1920, 859 deaths and in 1949 there were 28.

For malaria, changes in the number of deaths for the thirty year period are astounding. In S. C. in 1920 there were 198 deaths and in 1950 only 1. In the U. S. malaria figures are for the year 1920, 1,179 and for 1949, 23.

Although we usually think of smallpox as extinct, yet during 1920 there were 128 deaths in the U. S., but only 1 in 1949. Smallpox deaths in S. C. in 1920, 1 and in 1950, none.

Deaths from measles have decreased in S. C. over the 30 year period, but the changes in the U. S. are more striking. In 1920 there were 6,732 deaths and in 1949, 782 deaths. Figures for S. C. in 1920, 50 and in 1950, 20.

Even though scarlet fever at times is more virulent and epidemics more extensive, still in the 30 year period this would not be of any importance. Deaths in the U. S. in 1920, 2,937 and there were only 18 in 1949.

Most doctors and practically all pediatricians immunize their patients against whooping cough, so here we would expect a decrease in mortality. Deaths from whooping cough in S. C. for 1920, 367 and 1950, 45 and a more striking decrease in the U. S. in 1920, 10,605 and in 1949 only 721.

Quite naturally the immunization of the majority of babies and children against diphtheria has had a tremendous influence on that disease. Although in this paper no men-

*Read before the Greenville Pediatric Society, June 18, 1953.

tion is being made of the decrease in incidence of certain diseases yet the incidence can be roughly calculated by considering the relation of the number of deaths to the number of cases. In S. C. in 1920 there were 191 deaths from diphtheria but this had dropped to 23 in 1950. The decrease in deaths in the U. S. is even more striking for while there were 11,392 deaths from diphtheria in 1920 there were only 455 in 1949.

Even though we do not immunize against erysipelas, yet the treatment latterly is effective. There were 8 deaths from it in 1920 and none in 1950. Also in the U. S. in 1920 there were 960 deaths but only 6 in 1949. In other words in the U. S. 150 times as many children died in 1920 from erysipelas as died from it in 1949.

While there have been marked advances in diagnosis and treatment of tuberculosis in the last 30 years and even though we now have some drugs and procedures that are of considerable value, yet routinely immunization is not done. Therefore tremendous improvement in the mortality cannot be expected. Nevertheless, while there were 82 deaths in S. C. in 1920 there were only 13 in 1950 and in the U. S. the deaths declined from 6,967 in 1920 to 1,358 in 1949.

Although the advent of the Wassermann and other serological tests along with the finding of the treponema palidum under the microscope were most helpful in establishing the diagnosis of syphilis, and the administration of arsenicals and bismuth along with mercury and now penicillin, helped greatly in treatment, yet the incidence of congenital syphilis remained high. Some years ago the writer of this paper was on the program of the Tri-State Medical Association. He discussed the symptomatology and treatment of congenital syphilis with sulpharsphenamin citing over a half-dozen cases and showing radiograms of the long bones before and after treatment. These cases occurred in private practice, but today the situation is different. A baby who has syphilis is a rarity in my practice. Probably the two factors that have brought about this change are the routine testing of pregnant women for syphilis; and treatment, if necessary, for syphilis during their pregnancy. Ade-

quate and better pre-natal care has undoubtedly lessened the occurrence of syphilis in babies. In S. C. in 1920, 85 babies and children died from syphilis but in 1950 only 8 succumbed. In the U. S. in 1920 there were 2,089 deaths but in 1949, 318.

Within the last 30 years marked advances have been made in the diagnosis and treatment of diseases of the heart in childhood. Latterly surgery has been employed to remedy certain congenital anomalies previously considered incurable. This work has been pioneered chiefly in Boston and Baltimore. However, it is doubtful whether this newer surgery as yet has had much influence on the death-rate. In 1920 in S. C. 36 children died from heart disease and in 1950, 11 died. The mortality statistics for the U. S. are more striking for in 1920 there were 2,920 deaths while in 1949 there were only 606.

The term pneumonia is used for a variety of pathological conditions affecting the lungs. Also in the new-born frequently the condition is really atelectasis incorrectly so labeled and furthermore a large number of new-born who die have pneumonia as a terminal infection. Therefore, notwithstanding the use of the sulpha drugs, the anti-biotics, particularly penicillin, and the more frequent use of oxygen, the contrast over the years is not as striking perhaps as one would expect. In S. C., 790 babies and children died from pneumonia in 1920 and 267 died from it in 1950. In the U. S. there were in 1920, 39,384 deaths and in 1949, 11,025 deaths.

DEATHS UNDER 1 YEAR THROUGH 9 YEARS OF AGE

Population of S. C. 1920—	1,683,724			
Population of S. C. 1950—	2,117,027			
Population of U. S. 1920—	105,710,620			
Population of U. S. 1950—	156,697,361			
FROM:	South Carolina		United States	
	1920	1950	1920	1949
Typhoid	64	0	859	28
Malaria	198	1	1,179	23
Smallpox	1	0	128	1
Measles	50	20	6,732	782
Scarlet Fever	8	1	2,937	18
Whooping Cough	367	45	10,605	721
Diphtheria	191	23	11,392	455
Erysipelas	8	0	960	6
Tuberculosis	82	13	6,967	1,358
Syphilis	85	8	2,089	318
Heart Disease	36	11	2,920	606
Pneumonia	790	267	39,384	11,025

Since there has been a marked decrease in the number of deaths in many common diseases in children under nine years of age in

the three decades from 1920, let us consider some of the factors that may have been of importance.

Fluid of one kind or another given subcutaneously where there is dehydration, has become so routine a procedure that few of us know when it was introduced or by whom. While still of great value as well as being very simple, in many instances intravenous injection is preferable. Going one step further we proceed to transfusion. Even though by no means new, yet today it is instituted earlier, the blood is given in larger amounts and frequently the transfusion is repeated many times. While still not entirely without some danger, a severe reaction or death is extremely rare for our knowledge of hematology has greatly improved and much more care in matching is taken.

Prophylactic inoculations, especially against diphtheria, pertussis and typhoid fever are so routinely done that most mothers expect them. Even tetanus toxoid is now used by most doctors. This often obviates the giving of tetanus anti-toxin and unquestionably when indicated the toxoid is far better not only for the patient but for the doctor's peace of mind too.

The proper use of anti-biotics, which are numerous—perhaps too numerous—has shortened the course of many diseases and very often saved life. As yet we do not always use the anti-biotic that is best for a particular disease. Also some of these valuable and potent therapeutic agents do cause, in some patients, severe reactions.

The pharmaceutical houses, after considerable research and clinical trial, have brought out many—indeed too many—new drugs. Some of these are discarded after a period of use, but others are found to have merit and continue to be employed. Frequently however, with time and greater experience, the extravagant claims are modified. But on the whole it must be admitted that tremendous strides have been made in pharmacology within the past 20 or 30 years.

Hospitals are certainly not new. There are two in operation in London at the original sites now that were built in the middle of the twelfth century and in Paris there was one prior to that. Further in other lands some

were established many centuries earlier. Even so, hospitals as we know them, especially those for children, and children's wards are today better equipped and the management has greatly improved. Some carry on considerable research. Particularly this is true in Boston, New York City, Philadelphia, Baltimore, Chicago and many other cities. Especially in hospitals a diagnosis can be made earlier than formerly. This promptness at times is life saving. Of course this should not be surprising for with all the advances in medical science, in chemistry, in physics and in biology it is to be expected.

Today the medical colleges in the United States graduate annually a large number of doctors who have had excellent training and who have spent much time in the hospital wards. As a rule a doctor does not begin practice until he has had from two to five or more years service in a hospital as an intern or resident. The general practitioner knows far more pediatrics today than doctors did a generation ago. Pediatricians are very well trained in various childrens hospitals in the United States today.

The bio-chemist from whom little was received that was of any value thirty or forty years ago, now is able to render much help through his study of the body fluids, especially the blood and spinal fluid. Most of the complicated and tedious chemical procedures have been simplified and are done rapidly.

Although it is over fifty years since the roentgen ray was introduced, yet its better understanding and wider use has been of enormous value.

Having very briefly reviewed the progress in pediatrics for the past three decades let us now lift the curtain and try to peer into the future. Perhaps we can envision what may be accomplished by medical science within the next few years. Infantile paralysis which has loomed so large in the public eye and filled so many beds in orthopedic hospitals will soon be conquered. It is now believed by many that it can now be prevented through the administration of a vaccine.

Rheumatic fever is being studied more thoroughly and in time if not prevented will be treated even better than now.

Syphilis which formerly was extremely common in babies and children is now less frequent and it is not unreasonable to believe that in civilized countries where people have adequate medical care that it will be exterminated. However, because of the emotional factor and human frailty that time is not near.

Because of patients being sent to sanatoria and instructed how to prevent the spread of their disease, tuberculosis will steadily be lessened. In many countries the BCG vaccine is being used with great success. In August 1950, while in Stockholm, Dr. Arvid Wallgren, who was showing me through his hospital, in talking about tuberculosis, stated that in his opinion tuberculosis would be extinct in most countries within a few years.

All of us will not live to see cancer and leukemia conquered. Though there is still not sufficient evidence I believe that within a few years we shall know a great deal more about its origin and have better methods of treatment.

Congenital anomalies are still frequent and aside from surgery little can be done, but with the increase in knowledge of the physical, chemical and biological factors which affect the foetus, their incidence will be decreased. Already a vast amount of knowledge concerning genetics has been accumulated and ad-

vances are being made almost daily. This is of great practical value. In line with this, much work should be done, and probably will be, in preventing the extremely high number of premature births which is a leading cause of death.

"Accidents among children present a growing problem to parents and pediatricians. Three fatal accidents occur among children under 15 years of age every two hours throughout the year. The most frequent cause is motor vehicle accidents followed by drowning and burns. In the home, poisons taken accidentally cause many deaths. Accidents constitute the greatest single threat to children's lives."¹

SUMMARY

An attempt has been made to show that there has been a marked decrease in the number of deaths from a dozen diseases during childhood in South Carolina and in the United States between the years of 1920 and 1950. As a basis the mortality statistics of South Carolina and the United States have been used. Some of the most important factors that probably have been influential in this decline are discussed. In addition to comparing the past and the present, a glimpse into the future is given.

¹*Trends*, John P. Hubbard, M. D., *Pediatrics*, Vol. 2, #3, March, 1953.

All statistics used were from: Bureau of Vital Statistics, State Board of Health, Columbia, South Carolina.

Solid food in the neonatal period "in no way improves the health or well being of the baby," according to a report by Douglass. "The average healthy newborn, fed a formula simulating breast milk, will be happy and gain to double its birth weight in four months."

Douglass notes that despite advances in infant feeding, the gastrointestinal physiology of infants has not changed. The apparent early availability of enzymes for digestion of all simple foods except starches is based on studies which are qualitative, not quantitative.

It was found further, the author points out, that pancreatic amylase remains relatively deficient for some months in early infancy. Ptyalin is present in small amounts in saliva of the newborn, but it takes five to seven weeks for the development of noticeable saliva. Gastric acidity during the first month has been shown to be high the first two days, and then to fall off quickly. It does not tend to recover until after one month. This is a "significant"

manifestation of the instability of the gastrointestinal mucosa of the neonate, the author feels.

Douglas, F. H.: Northwest Med. 52:832 (October) 1953

A certain physician had the unusual pastime of playing poker. Each night when he came from the game his wife met him at the door and, among other things, wished to know what his luck had been. As usual she shared all profits, but none of the losses. One particular night he came in and was asked about his luck. He stated that he almost broke even. After a search of his pocketbook (which was empty) the doctor finally admitted that he was even until the last hand in which his pair did not hold up. As a result he owed Sam Jones a shot of penicillin, Jack Johnson a cancellation of his two year account and Mrs. Frank James a hemorrhoidectomy free of charge.

Annual Meeting of The South Carolina Medical Association

MYRTLE BEACH, S. C.—MAY 11, 12, 13, 1954

Tuesday, May 11, 1954—Meeting of the House of Delegates, 10 A. M.

Wednesday, May 12, 1954—2:00 to 4:00 p. m.

Panel on Non-Tuberculous Diseases of the Chest

Moderator: Dr. David T. Smith, Durham, N. C.

Medicine: Dr. John H. Seabury, New Orleans, La.

Pediatrics: Dr. Richard W. Blumberg, Atlanta, Ga.

Surgery: Dr. Rollin A. Daniel, Nashville, Tenn.

Radiology: Dr. Harold Pettit, Charleston, S. C.

Wednesday, May 12, 1954—4:00 p. m.

"The Changing Epidemiological and Clinical Pattern of Pulmonary Tuberculosis." — Dr. David T. Smith

Evening Meeting of Alumni Association

Thursday, May 13, 1954

9:15 a. m.—Memorials.

9:30 a. m.—President's Address—Dr. C. R. F. Baker, Sumter, S. C.

10:00 a. m.—"Emergency Treatment of Head Injuries"—

Dr. William H. Bridgers, Columbia, S. C.

10:30 a. m.—"The Treatment of Common Skin Diseases"—

Dr. Kathleen Riley, Charleston, S. C.

11:00 a. m.—"The Value of Exfoliative Cytology in Diagnosis"—

Dr. Rawling Pratt-Thomas, Charleston, S. C.

11:30 a. m.—Time for Visits to Exhibits.

11:45 a. m.—"Common Proctological Problems"—

Dr. Louis E. Buie, Mayo Clinic, Rochester, Minn.

1:00 p. m.—Luncheon.

2:30 to 4:00 p. m.—Obstetrics — Gynecology — Pediatrics Panel—

Moderator: Dr. William R. DeLoache, Greenville, S. C.

Pediatrics: Dr. Amos Christie, Nashville, Tenn.

Obs.-Gynecology: Dr. Norman Thornton, Charlottesville, Va.

2:30 to 4:00 p. m.—Medical—Surgical Panel on Peptic Ulcer—

Moderator: Dr. Henry Mayo, Charleston, S. C.

Internist: Dr. Franz J. Ingelfinger, Boston, Mass.

Surgical: Dr. Cranston W. Holman, New York, N. Y.

Radiologist: Dr. George J. Baylin, Durham, N. C.

4:00 p. m.—Visits to exhibits.

4:15 p. m.—"The Treatment of Liver Disease"—

Dr. Franz J. Ingelfinger.

5:00 p. m.—Adjournment.

7:00 p. m.—Cocktails. (Courtesy of Van Pelt and Brown).

8:00 p. m.—Banquet. Address by Hon. James F. Byrnes, Governor of South Carolina.

PRESIDENT AND PRESIDENT-ELECT

- 1954 -



C. R. F. BAKER

President of The South Carolina Medical Association

Dick Baker was born in Sumter, S. C., on February 23, 1902, both a son and grandson of doctors. His father was Dr. Samuel Chandler Baker, who in 1909 was president of the S. C. Medical Association, and who was one of the earliest members in South Carolina of the American College of Surgeons, having been elected a fellow in 1914; and his grandfather, Dr. Charles Richard Furman Baker, also known as "Dick," was a close friend and college mate at the University of South Carolina (then known as South Carolina College) and at the Medical College in Charleston of Dr. Marion Sims.

Dick Baker is a graduate of Episcopal High School in Alexandria, Va., and of the University of Va., where he received both his B. S. and M. D. degrees. He received his surgical training in New York City—two years at St. Luke's and two more years at New York Hospital, now a part of Cornell Medical Center. In 1930 he was assistant to Dr. R. L. Ramey, pioneer surgeon of El Paso, Texas, and in 1931 he returned to Sumter, and established his surgical practice. In 1935 he was elected to membership in the American College of Surgeons, and in 1941 was certified by the American Board of Surgery. He was a charter member of the South Carolina Surgical Society and as its first vice-president served as president after the death of Roger Doughty. He was a member of the council of this Association for nine years, and was active on the committee which established Blue Shield in this state, and headed its central professional committee for three years.

Dr. Baker is an Episcopalian, a Rotarian, a member of Kappa Sigma, Phi Beta Kappa, and Alpha Omega Alpha fraternities. He was married in 1932 to the former Mary Shipp of Florence and is the father of one son, Dick Baker, Jr., who is a pre-medical student at Princeton.



THOMAS R. GAINES

President-Elect of the South Carolina Medical Association

Dr. Gaines was born in Hart County, Georgia, in 1895. He was educated in the country schools of that section and at Gibson-Mercer Academy, Bowman, Georgia. He received his medical degree from Emory University, Atlanta, 1916. He served in the Medical Corps, U. S. Army, on the Mexican Border and in World War I, 1916-1919. From 1920-1925 he engaged in general practice in Hartwell, Georgia, after which he pursued postgraduate work and residency in Eye, Ear, Nose and Throat at New Orleans Eye, Ear, Nose and Throat Hospital, 1925-1926. He has been in the practice of ophthalmology and otolaryngology at Anderson from 1927 to date, with the exception of three years in the Army Medical Corps during World War II. Dr. Gaines is a Fellow of the American College of Surgeons and a Fellow of the American Academy of Ophthalmology and Otolaryngology.

SPEAKERS



LOUIS A. BUIE, M. D.

A. B., University of South Carolina—1911.
M. D., University of Maryland—1915.
D. Sc., University of South Carolina—1949.
Alumni Honor Award, Medical Alumni Association,
Univ. of Maryland—1952.
Senior Consultant, Department of Proctology, Mayo
Clinic.
Professor of Surgery (Proctology), Mayo Foundation,
University of Minnesota.
Member of Judicial Council, member of House of
Delegates and Chairman of the Council on Con-
stitution and By-laws of the American Medical
Association.
Secretary of the American Board of Proctology.
Vice-Chairman of the General Advisory Committee of
the National Foundation for Infantile Paralysis, Inc.
Member of Committee on Relationships between Med-
icine and Allied Health Agencies.
Author of numerous books and over 100 scientific
articles on medical and surgical topics.



FRANZ J. INGELFINGER
Boston

FRANZ J. INGELFINGER

Ingelfinger, Franz Joseph, physician; b. Dresden,
Germany, August 20, 1910; s. Joseph and Eleanor
(Holden) I.; A. B. Yale, 1932; M. D., Harvard Med.
Sch. 1936; m. Sarah Shurcliff, Aug. 23, 1941; chil-
dren—Joseph Abbott, Alice; came to U. S. 1922,
naturalized, 1931. Interne, Boston City Hospital, 1937;
fellow Thorndike Memorial Lab., resident Boston City
Hosp., Asst. in medicine, Harvard Med. Sch., 1938;
fellow gastroenterology and asst. in medicine, U. of
Pa. Hosp. 1939; instr. medicine, Boston U. Sch. Medi-
cine, 1940-42, asst. prof., 1942-45, assoc. prof. since
1945; mem. R. D. Evans Mem. Hosp., Boston since
1944; visiting physician and chief G-I Clinic, Mass.
Memorial Hosp. since 1943; chief G-I Clinic, Cushing
V. A. Hosp. since 1950. Diplomate Am. Bd. Internal
Medicine; mem. Am. Med. Assn., Am. Society Clin.
Investigation, A.A.A.S., Am. Gastroent. Assn., Assoc.
of Am. Physicians; Phi Beta Kappa, Alpha Omega
Alpha, Beta Theta Pi, Nu Sigma Nu. Club: Aescula-
pian (Boston, Mass.). Author of chapters in text books
and articles on internal medicine in med. journals.
Home: 28 Hubbard Park, Cambridge 38, Mass.
Office: 65 E. Newton Street, Boston 18, Mass.

Trustee of Boston Medical Library, 1952.

Councilor, Mass. Medical Society, 1952.

Consultant in Gastroenterology, Boston VA Hospi-
tal, 1952.

Chief, G-I Clinic, Cushing VA Hospital, 1950-1952.
Editor, Gastroenterology Section, Year Book of
Medicine, 1953.

Director, Postgraduate Medical Institute (Boston)
1953.

Member, Interurban Clinical Club, 1953.



CRANSTON W. HOLMAN

A. B., Stanford University, 1927.

M. D., Stanford University, 1931.

Associate Professor of Clinical Surgery, Cornell Uni-
versity Medical College, New York, N. Y.

Attending Surgeon, New York Hospital.

Director, Second (Cornell) Surgical Division, Belle-
vue Hospital, New York, N. Y.

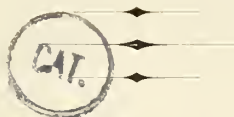
Consultant Surgeon, Veterans Hospital, Montrose, New
York.

Consultant Surgeon, Veterans Hospital, 23rd Street,
New York, N. Y.



DAVID T. SMITH

David T. Smith, A. B., M. D., LL. D. (honorary), past president of Durham-Orange County Medical Society, past president of Durham County Tuberculosis and Health Association, past president of North Carolina Tuberculosis Association, past president of National Tuberculosis Association. Author of over a hundred scientific articles, monograph of Fusospirochetal Diseases and monograph on Fungus Diseases of the Lungs. Co-author of the 9th and 10th editions of Zinsser's Textbook of Bacteriology and 2nd ed. of Manual of Clinical Mycology.



JOHN HOLLISTER SEABURY, M. D.

Born: Detroit, Michigan, December 24, 1910.
 University of Michigan,
 B. S., June 1933.
 M. S., June 1934.
 M. D., June 1940.
 University Hospital, Ann Arbor, Michigan,
 Intern, 1940-41.
 Resident in Internal Medicine, 1941-43
 University of Michigan,
 Instructor in Medicine, 1943-45
 Louisiana State University School of Medicine,
 Assistant Professor of Medicine, 1945-49
 Associate Professor of Medicine, 1949 to date
 Visiting Physician in Medicine, LSU Unit, Charity
 Hospital, 1945 to date
 Director of the Lung Station, Charity Hospital, 1945
 to date
 Diplomate of the American Board of Internal Medicine,
 1947
 Member of American College of Chest Physicians,
 American Society for Tropical Medicine, American
 Federation for Clinical Research, Orleans Parish and
 Louisiana State Medical Societies, New Orleans
 Academy of Internal Medicine



GEORGE J. BAYLIN

Graduated from Duke Medical School in 1937, took graduate work in pathology in England, and did surgical work in Baltimore, then returned to the X-ray Department at Duke. Finished residency in 1942 and since that time has been affiliated with the Department at Duke, and is now Professor of Radiology. Born in Baltimore, Maryland in 1911 and attended public schools there and graduated with an A. B. degree from Johns Hopkins University.





KATHLEEN RILEY

Furman University—B. S., 1937.
 Medical College of S. C.—M. D., 1941.
 Internship—Garfield Hospital, Washington, D. C., 1941-42.
 Residency in Dermatology and Syphilology—Duke Hospital, Durham, N. C., 1944-48.
 Assistant Professor of Dermatology—Medical College of S. C.



H. RAWLING PRATT-THOMAS

Born Barnsley, England. Reared in Sumter County, S. C.
 A. B. degree Davidson College, 1934. M. D. degree Medical College of S. C., 1938. Internship and Residency, Cincinnati General Hospital.
 Member American Medical Assn., Southern Medical Assn., S. C.
 Medical Assn., American Association of Pathologists & Bacteriologists. Former Chairman, Section on Pathology of Southern Medical Association. Member of Faculty of Southern Pediatric Seminar. Diplomate of American Board of Pathology.
 Present Position: Professor of Pathology, Medical College of S. C.
 Married: Mary Porcher Douglas, 4 children.
 Hobbies and Chief Interests: Too many.



WILLIAM R. DeLOACHE, M. D.

M. D., Vanderbilt University School of Medicine, 1943.
 Interne and assistant resident at Vanderbilt University Hospital, 1944, and from 1947-48.
 Assistant resident, Bowman Gray School of Medicine, 1948-49.
 U. S. Army Medical Corp., 1944-46.
 Private Practice, Greenville, South Carolina, 1949—present.
 Licentiate of the American Board of Pediatrics. Fellow of the American Academy of Pediatrics.



HENRY W. MAYO, JR.

I was born April 5, 1914, in Brooklyn, New York, received my B. A. from Dartmouth College in 1936, and my M. D. from the University of Virginia in 1940. I interned on the Surgical Service of the New York

Hospital (Cornell) from 1940-1941, and was a Junior Surgical Resident at the University of Virginia Hospital from 1941-1942. I was in the Army of the United States for three-and-one-half years, three years of this time being spent in Africa, Italy, France and Germany in the Eighth Evacuation Hospital and the Third Infantry Division. I was discharged from the service with the rank of Major.

After the war, I returned to my training at the University of Virginia, receiving an M. S. in Surgical Pathology in 1948, and finishing the Senior Surgical Residency in 1949. I have been at the Medical College of South Carolina since September, 1949, and my present rank is Assistant Professor of Surgery.



WILLIAM H. BRIDGERS

Dr. William H. Bridgers was born in Newport News, Virginia, and received his B. S. degree from Duke University. He graduated from the Duke University School of Medicine in 1936. Following an internship in surgery at Duke Hospital, he served a three year residency in surgery at Duke Hospital. While at Duke Hospital he had a residency in Neurosurgery under Dr. Barnes Woodhall. He received a fellowship in Neurological Surgery at the Montreal Neurological Institute under Dr. Wilder Penfield. He received a M. Sc. degree in Neurological Surgery from McGill University.

During World War II, Dr. Bridgers entered the United States Army as the Neurosurgeon for the 65th General Hospital, which was the Duke Hospital affiliated unit. He was chief of a Neurosurgical Center in England for approximately two years. Following his return to the United States he was chief of the Neurosurgical Center at Halloran General Hospital, New York, until his discharge from the Army.

Dr. Bridgers is a diplomate of the American Board of Neurological Surgery. He is a member of the Neurosurgical Society of America, the Harvey Cushing Society, the Southern Neurosurgical Society and a Fellow of the American College of Surgeons.

He is the consultant in Neurological Surgery to the Veteran's Administration Hospital and also to the Fort Jackson Station Hospital. He is medical advisor to the South Carolina Physical Therapy Association, Inc. He practices Neurological Surgery in Columbia and is consultant in Neurological Surgery to the Camden Hospital.



AMOS CHRISTIE, M. D.

Born: August 13, 1902, Eureka, California.

Degrees: B. S. 1924 University of Washington, Seattle, Washington.

M. D. 1929 University of California Medical School San Francisco.

Appointments:

Rotation internship, Alameda County Hospital, 1928-1929.

Pediatric internship, Babies Hospital, College of Physicians and Surgeons, Columbia University, New York, 1929-1930.

Instructor in Pediatrics, University of California Medical School, 1938-1942.

Visiting Pediatrician, San Francisco Juvenile Court and Infant Shelter, 1931-1935.

Research Associate, Johns Hopkins University, 1936-1937.

Assistant Visiting Pediatrician and Obstetrician, Johns Hopkins Medical School, 1936-1937.

Specialist in Pediatrics, Children's Bureau, U. S. Department of Labor, Washington, D. C., 1936-1937.

Assistant Professor of Pediatrics, University of California Medical School, 1937-1939.

Lecturer in Curricula of Public Health, University of California, 1938-1939.

Associate Professor of Pediatrics, University of California Medical School, 1939.

Acting Head, Department of Pediatrics, January to August, 1940.

Assistant Director, Medical and Health Services, American Red Cross, National Headquarters, Washington, D. C., 1942-1943.

Professor of Pediatrics, Vanderbilt University School of Medicine, Nashville, Tennessee, 1943.

Affiliations with Medical Societies:

Society for Pediatric Research (National); American Pediatric Society (National); American Public Health Association (National); Member California State Board of Health, 1940-1942; Nashville Academy of Medicine; Executive Committee of the Advisory Board for Health Services, American Red Cross, (National); American Board of Pediatrics; AOA; Sigma Xi; Association of American Physicians; President of the Tennessee Pediatric Society; President of the Nashville Pediatric Society; Chairman, Pediatric Section, Southern Medical Association.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

J. P. Cain Mullins
J. D. Guess Greenville
C. J. Milling Columbia
H. R. Pratt-Thomas Charleston

EDITORIAL BOARD

Vince Moseley Charleston
Ben Miller Columbia
W. H. Prioleau Charleston

G. D. Johnson Spartanburg
R. M. Pollitzer Greenville
Hugh Smith Greenville
Walter Mead Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Charleston, S. C.

Subscription Price

\$3.00 a Year

APRIL, 1954

THE ANNUAL MEETING

After a brief absence, the Association returns to Myrtle Beach on May 11, 12, 13. The excellent program deserves a large attendance. The pleasures of the beach are to be had as before, and the opportunity to meet old friends and see the new faces in an atmosphere of relaxation is unexcelled. A record crowd is to be expected.

A ROSE IN THE HAND

A grateful patient has expressed his appreciation to two Columbia physicians and to Columbia Hospital by donating \$5,000 to be used for the purchase of new, upholstered wheel chairs for the institution. A plaque in the hospital's corridor, in connection with the gift, is unusual in that it honors two living physicians. It reads:

In appreciation of
the fellowship and ability of
DR. O. B. MAYER
and
DR. A. T. MOORE
a grateful patient donated
new wheelchairs to the Columbia Hospital
* * *

"A rose to the living is worth
a thousand to the dead"
A CITIZEN OF SOUTH CAROLINA

POSTMATURITY

The problems of the premature infant overshadow those of the postmature. A recent article* points out that the baby who is postmature because of placental dysfunction is a

*Clifford, Stewart. J. Ped. 44 Jan. 1954, 1-13.

small, malnourished baby who suffers from anoxia and may well perish. Furthermore, 73 per cent of the mothers of these babies do not again become pregnant.

The program at Myrtle Beach will include a discussion of this subject, to which little attention has been directed.

HAZARDS TO OUR KIND OF MEDICINE

With Gov. Earl Warren, a vigorous proponent of socialized medicine, added to the Supreme Court, and with the failure of the Bricker amendment, American medicine has had two possible strikes against it—not imminent or urgent, but maybe insidious.

MEDICAL LITERARY PROGRESS

Some time back there was a worthy physician who lived in Charleston. He was a writer and a translator, and of medical papers he said, "... one in a hundred is worth the Time a Man spends in perusing them, and all the Matter that may be picked out of them, either for informing the Understanding, or improving the Art, might be wrote upon the Back of a Card, if not the Author's Thumbnail."

This was Dr. Thomas Dale, and the date was 1732. We wonder whether he would be more charitably inclined to the enormous mass of current medical writing.

GAMMA GLOBULIN GLOOM

The tumult and the shouting die, and gamma globulin seems to depart from the promised place in the prevention of poliomyelitis.

A committee of experts asked by the Public

Health Service, U. S. Department of Health, Education and Welfare, to evaluate data collected last summer to study the effectiveness of gamma globulin as used to prevent or alleviate poliomyelitis, has reported that beneficial effects were not demonstrated either in the inoculation of family associates of polio cases or in the mass inoculation of children in epidemic areas.

Observation of the 23 communities in which mass inoculation of children was carried out did not provide enough information to permit the committee to conclude whether or not gamma globulin had an effect in preventing or alleviating the disease when used in this way, the committee said.

Among the cities where gamma globulin was administered on a mass basis to all children last summer, the committee's report said that in most of them the inoculations were given after the peak of the epidemic had been passed, so there was little chance to demonstrate an effect of gamma globulin in modifying the epidemic.

The committee expressed the opinion that demonstration of the efficacy of gamma globulin under the conditions pertaining to mass inoculations would require larger experience with greater opportunity for scientific observation.

The committee did find, however, that the "family contact" use of gamma globulin, where members of the household of a polio case were inoculated as soon as the illness was recognized, did not measurably reduce the number of subsequent paralytic cases in these households.

Moreover, the committee said their study of the family contact use indicated that when gamma globulin was administered to exposed persons before they came down with paralytic polio there was no measurable effect on the severity of the ensuing paralysis.

The committee of 20 experts, including leading polio researchers, as well as some State and city health officials, reached their conclusions after a three-day meeting in Atlanta, Georgia, recently. They studied medical data from all parts of the country which had been collected and analyzed since the end of last year's polio season by the staff of the Service's

Communicable Disease Center, which coordinated the evaluation effort.

In 1953 South Carolina received an allocation of 13,220 cc. of gamma globulin for use in poliomyelitis prevention. Of this amount, 10,094 cc. were used in 31 counties. This was given to 923 contacts of diagnosed cases, an average of 10.3 cc. for each individual contact.

For each of the 170 cases reported, an average of 59.4 cc. of gamma globulin were used. There were six households in which there was more than one case. In five of these, two cases occurred; and in one, three cases.

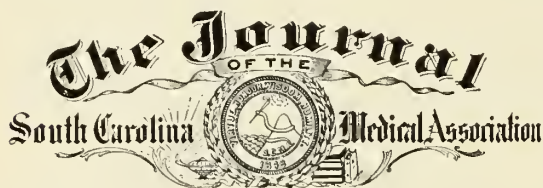
COURTESY AND CUSTOM

It is the privilege of every older medical generation to bemoan the decline in the customs and manners of a newer one. While the character of basic ethics may not change much, and certainly medical human nature does not show any remarkably radical change for the better, there seem to be certain trends in the approach to several matters, perhaps minor after all.

Certainly no physician has any hold on a patient beyond what the patient wishes him to have. A patient is neither mine or thine. But once upon a time when a physician was called to see a patient in more or less of an emergency, or in the temporary absence of a confrere, he made inquiry as to who the usual physician was, and having met the immediate medical need, sent the patient back to his previous doctor. Now we seem to hear of many instances in which the physician handling the emergency instructs the patient to come back to him for further treatment and, by inference, permanent connection. Such an arrangement sounds more like business promotion than professional courtesy.

There still survive a scanty few physicians who observe the old courtesy and custom by which it became the prerogative of any doctor to look after the patients of a fellow doctor who is ill, and to allow the sick professional friend to send in a bill for the services. This is a practice which can very well get out of hand. The rugged individualist scorns such help. Prolonged illness of a fellow doctor certainly puts a burden on the active physicians, especially where there are few doctors

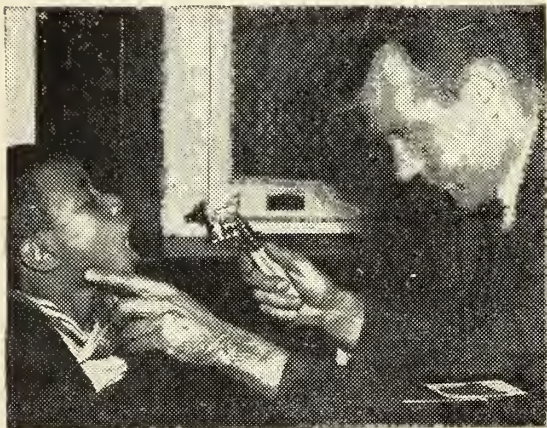
in a community and the extra burden may become heavy. There are things to be said for and against the custom. But in the case of brief illness what a nice gesture of professional solidarity it is. The recipient of such favors can always reciprocate in some appropriate manner, a friendly turn has been done, and professional relations seem a bit warmer.



Forty Years Ago

APRIL 1914

The Annual Meeting reported as a great success. It was suggested that the number of papers be reduced from forty or fifty to thirty. Dr. G. A. Nenflier had a paper on "Bugs"—i. e., bacteria. — Dillon County reported of its meeting that "there was quite a number of the physicians of the county present, and all seemed to be more enthusiastic than usual." — The Secretary of the Aiken County Society reported that "Dr. Bryant read a very interesting paper, the subject which we are sorry we haven't on hand."



HELP CRIPPLED CHILDREN

The appeal "Help Crippled Children," symbolized in the traditional Easter Seal, will make its impact felt in millions of American homes again this Easter Season. It will re-emphasize for the twenty-first year that Easter is a time of new hope and of rebirth for crippled children.

The response this message should evoke in us is that there is no better way of observing this season than to help make possible the care, treatment and rehabilitation which will enable these little ones to walk, talk and live like other children.

And we can help, for our contributions to Easter Seals will assure the continuation and expansion of medical care, therapy, recreation and special educational services of the more than 1,200 crippled children's societies united in the National Society for Crippled Children and Adults throughout the 48 states, Alaska, Hawaii, Puerto Rico and the District of Columbia. During 1952-53 here in South Carolina 3446 children and adults were aided by Easter Seal funds.

Easter Seal funds, received during the appeal month, March 18 to April 18, will be used here in South Carolina for the diagnostic cerebral palsy clinics, treatment and training centers, special classes, where vital services are given to crippled children and adults.

In face of rising costs and with increasing numbers of children asking care, the need becomes greater each year, making necessary broader and fuller public support. The South Carolina Medical Association yearly appoints a Medical Advisory Board to the Crippled Children Society of South Carolina, Inc., the Easter Seal Society. Thus we aid in solving problems of policy for the organization. A. L. M. Wiggins, Hartsville, serves as state president with Mrs. T. Jackson Lowe as state executive director. Let's make sure that our contributions are adequate to the need, as well.

PLACEMENT SERVICE

ROBERT WILSON, Secretary

At the 1953 meeting of the House of Delegates, at the suggestion of the Secretary and on recommendation of the Council, a Placement Service was established for the State under the auspices of the South Carolina Medical Association. It was directed that the work of this bureau was to be carried out by the Secretary and the Executive Secretary.

The general idea of Placement Service is to enable physicians looking for a location for practice to find those communities where their services are needed, and to help such communities find a doctor. The Placement Service acts simply as a center for the exchange of this kind of information. Inquiries are received from physicians who are interested in practicing medicine in the State and whatever information is available is relayed to them; no attempt is made either to recommend a physician to a community or a location to a physician as it is felt that this must be finally decided only after personal investigation and mutual agreement.

The Placement Service has been active since last summer and its operation has been purposely kept simple. A list of communities where it has been reported that a physician is needed has been tabulated and sent to all doctors who have made inquiries as to the opportunities for practice in the state. No attempt at personal investigation of these communities to see whether or not the need is real has been possible. It would be ideal to be able to investigate each community thoroughly as to population, availability of hospital facilities, ability of the community to support a physician, habits of the people in regard to using local doctors or going to a neighboring town, and availability of adequate housing, churches, schools and recreational facilities, but all of these important factors would have to be investigated personally by the individual doctor thinking of settling there.

A few requests have come from physicians wanting help in their practice, for an assistant or an associate, and these doctors have been supplied with lists of physicians who have registered with the service as

Counties	Total Popula- tion	Total Doctors	G-P	Surg.	I-M	Ped.	Ob.- Gyn.	Ortho.	G-U.	Eent.	Others
Abbeville	22,000	9									
Aiken	53,000	19	16	1	1	1					
Allendale	11,000	7	7								
Anderson	90,000	63	33	5	3	5	4	1	3	6	3
Bamberg	18,000	8									
Barnwell	18,000	10	10								
Beaufort	17,000	7	7								
Berkeley	27,000	8	7	1							
Calhoun	15,000	5	5								
Charleston	165,000	140	37	15	19	13	11	4	6	10	25
Cherokee	35,000	11	11								
Chester	33,000	11									
Chesterfield	36,000	11	11								
Clarendon	32,000	6	5	1							
Colleton	28,000	14	14								
Darlington	50,000	18	15	1	1					1	
Dillon	31,000	9	9								
Dorchester	23,000	9	9								
Edgefield	17,000	7	7								
Fairfield	22,000	5	5								
Florence	80,000	52	29	6	4	2	2	2	2	5	
Georgetown	32,000	15	13	1		1					
Greenville	168,000	106	31	20	13	11	10	4	5	7	5
Greenwood	42,000	25	11	6	2	2	1	1		2	
Hampton	18,000	10	10								
Horry	60,000	25	15	3	2	1	1			1	2
Jasper	11,000	5	5								
Kershaw	32,000	15	13	1		1					
Lancaster	37,000	11	8	2						1	
Laurens	47,000	16	16								
Lee	23,000	6	5	1							
Lexington	44,000	13	13								
McCormick	10,000	2	2								
Marion	33,000	19	12	4	2	1					
Marlboro	32,000	13	11	2							
Newberry	32,000	22	15	2	2	1				1	1
Oconee	39,000	16	15	1							
Orangeburg	69,000	42	23	4	3	1	1		2	2	6
Pickens	40,000	22									
Richland	143,000	188	55	25	24	10	11	9	7	10	37
Saluda	16,000	3	3								
Spartanburg	150,000	105	53	13	9	6	6	1	4	6	7
Sumter	58,000	31	10	8	2	1	3		1	4	4
Union	31,000	11	11								
Williamsburg	44,000	12	9							1	2
York	72,000	37	20	6	4	2	1		1	2	1
Totals	2,106,000	1199	617	129	91	59	51	22	31	59	93

interested in this type of work. A number of requests for a *locum tenens* have been received but so far no opportunities for work of this nature has appeared.

Many inquiries have been received from physicians for a variety of reasons, both from within the state and from without. Some simply desire a change of location for personal reasons, others have thought that the Southeast or the State of South Carolina offered more opportunities in the long run than the location in which they were at present and have thought of coming to our state. Some have been physicians who have been released from the armed services and some who have retired from other full time work. A number

of inquiries have come from young physicians in internships and residencies who are looking for their first location for practice. However, most of the communities have needed or wanted general practitioners only, and a surprisingly large percentage of physicians looking for locations have been specialists in one field or another and are not themselves interested in a general practice.

As a part of the service of the Placement Service it was felt that a survey of all physicians practicing in the State would be of interest and of help, especially to those interested in some specialized type of practice, and an attempt has been made to gather this informa-

tion together. An inquiry has been sent to each County Secretary and to the Councilor of each District as to the number of physicians practicing in their communities, along with the number of the various types of specialty practice, and the results of this survey are appended in the table on page 117. No attempt has been made to draw any inferences from the statistical information obtained but it is hoped that it might be of some help to physicians looking for locations in which to practice in the state.

ANNUAL REPORTS TO THE HOUSE OF DELEGATES

COMMITTEE ON MATERNAL WELFARE

The work of the Committee on Maternal Welfare of the South Carolina Medical Association has continued along lines followed for the past several years. Quarterly meetings have been held in Columbia. Reported deaths have been reviewed and discussed, and all doctors who have sent in reports regarding the cases have been given a resumé of the discussion, together with any worthwhile suggestions which have been brought out.

Several things have hampered and affected adversely the studies. There is such a time lag between the time of death and the time the death certificates reach the committee office, that doctors are usually asked to fill out questionnaires months (up to 12) after the deaths occur. This not only causes unnecessary trouble to them in looking up old records, but interest in the case and a keen consciousness of the events has long since gone. Since the time lag is caused by the reporting technique and a shortage of clerical help in the Bureau of Vital Statistics, there is nothing that the committee can do about it.

Another important factor tending to slow down the work and decrease the interest was occasioned by the fact that in the first half of the year, the chairman was overloaded, and during the second half, an impairment in his health made necessary some slowing down. He had asked to be relieved prior to last year's annual meeting, but his request was not granted. However, there will be a new chairman next year, and no doubt he will bring interest, energy and initiative back to the committee and its work.

In making this my last report for the committee, I want to repeat again, as I have done each year, my sincere appreciation of the interest and the assistance of the several members of the committee and members of the Committee on Maternal Welfare of the South Carolina Obstetrical and Gynecological Society and those of a similar committee of the Columbia Medical Society, to members of the state office and the field offices of the State Board of Health, and especially of the Division of Maternal and Child Health, and finally and most sincerely to Dr. Hilla Sheriff, who has acted as secretary to the committee throughout its life, who has furnished clerical help to get out the questionnaires, and has provided a mileage allowance for attendance of committee members at the meetings.

J. Dechard Guess, M. D.
Chairman

The success of Placement Service depends altogether on the information furnished as to the availability and suitability of communities needing doctors. The responsibility for reporting such opportunities to the Placement Service cannot devolve on any one individual but must depend on each one who knows of any opportunity reporting this to the Placement Service so that this information can be relayed to all inquirers.

COMMITTEE ON INDIGENT CARE

During the past year, the Committee on Indigent Care met with a Committee appointed by the Governor and along with Mr. Frenzel a survey of the entire State relative to present medical facilities and care was made. When these facts and figures were assembled, then a plan was gotten together that the committee thought would answer the purpose of our State as far as the care of the Indigent was concerned. Mr. Buchanan of Columbia, South Carolina, is Chairman of this Committee. The completed plan as well as the survey, was to be printed and distributed widely over the State to those persons most concerned, including the Medical profession. So far, this has not been done. It is thought perhaps the delay in taking action on this plan has been brought about by the emphasis on increased funds for education in the State in the past two years, and this may continue for another year or two causing further delay in instituting a concrete plan. It is hoped that during the forthcoming year the plan at least will be presented as gotten out by the Committee.

Respectfully submitted,
John K. Webb, M. D.

INSURANCE COMMITTEE

This Committee was appointed with two aims in view. First, that since it was felt that certain benefits accrued when insurance is taken on a group basis which are not available when taken on an individual basis, that study should be made to determine what extra benefits, if any, the South Carolina Medical Association would have by being insured as a group. The various types of insurance to be studied were:

1. Malpractice Insurance
2. Health and Accident Insurance
3. Life Insurance
4. Pension Plan

Second, a thorough study be made of existing hospital benefit policies available to the public and recommendations as to improvements therein.

1. *Malpractice Insurance* on a group basis—Aetna, U. S. Fidelity, Travelers contacted—not feasible for group insurance of this type. Larger the group—more the legal hazard encountered. Not recommended.

2. *Health and Accident Insurance* is well covered at the present time through World Insurance Company and United Benefit with South Carolina Medical Association, American College of Surgeons, and other

specialty groups.

3. *Life Insurance*—Because of the fact that many physicians of our Association are uninsurable from various causes and may desire or need additional coverage, we believe that a form of group life insurance available to members without examination will be helpful to some of our members.

4. *Pension Plan*—Proposals from several companies were studied by the Committee. From the proposals it was obvious that more liberal benefits were available when this was taken on a group basis rather than individuals. In fact, the benefits equaled thirty five to forty percent more. For this reason, we feel that our Association should endorse a group pension plan.

Also considered was the fact that the Jenkins-(Keogh)-Reed Bill, allowing physicians to deduct from their taxable income premiums paid on retirement income plans, is still being considered by Congress and may be enacted into law before our State Meeting. It is all the more important that a pension plan be considered at this time.

Hospital Insurance—for the Public:

Since gross inadequacies exist in many policies now sold to our patients either by false statement of the agents or through misleading advertising—and since it is a source of keen disappointment to a patient to suffer an illness which requires hospitalization to find that his policy fails to cover the illness. And also since the hospitals and physicians have a financial interest, as many people who are insured do not make other provision for payment, we feel that the South Carolina Medical Association should take a stand to insure the sale of bona fide, honest policies that give the public reasonable coverage.

We recommend that the South Carolina Medical Association set up

1. A model policy to serve as a goal toward which to work and to be used as a guide in comparing different contracts.

2. An education program to persuade patients who wish to buy hospital policies to read their policies and consult their doctors or hospitals when in doubt as to the coverage before the policy is accepted.

3. Legislative recommendations:

- a. Have physical examinations required before policy is issued and all policies issued after such an examination be free of any restriction.
- b. Clear language—plainly written in non-technical terms(medical or legal) so patient may understand fully what his coverage provides and the elimination of exclusions which are sometimes found in policies written in very small unemphasized print.
- c. Train and regulate agents so that they will select good risks and represent the policies fairly.
- d. Standard form blanks for hospitals and physicians.
- e. Elimination of weekly claim blanks used by Industrial Insurance Companies which have to be completed each week—the bane of the

average G-P's existence—and in its stead the use of the Standard form referred to above.

The Committee feels that an Insurance Committee should be retained by the Association and given authority to act on approval of the Council as to putting into effect any of the above recommendations which are wanted by the Association.

Committee: Richard W. Hanckel
Eugene D. Guyton
Joseph P. Cain, Jr., Chm.

COMMITTEE ON PUBLIC RELATIONS

Soon after accepting the chairmanship of this committee your Executive Secretary, Mr. M. L. Meadors, and I attended the second Medical Public Relations Institute, put on by the A. M. A. in Chicago on September 2 and 3, 1953; in order that we might get a better understanding of the P. R. problem in general and what was being done about it. An excellent program had been arranged and was very ably presented. It will not be necessary to bore you with details, suffice it to say that I was very agreeably surprised to find that we were not doing too badly in South Carolina when measured by the National yard stick. I would like at this point to commend Jack Meadors for the excellent job he has done for us. We have found him most cooperative and helpful.

During the year there have been many Public Relations activities throughout the state and while your committee does not claim credit for many of them they should be mentioned in order that you may have the benefit of the over all picture.

This year has seen the birth of the Public Forum idea in South Carolina, which has proven so successful elsewhere; notably in Atlanta, Ga. and St. Petersburg, Fla. Through the efforts of your committee a Forum is being developed in Florence. We had decided upon this location as a good testing ground; however, Forums are already in progress in Columbia and Greenville without stimulus from any outside force, so that it appears that the movement is well under way. Based on experiences elsewhere we can certainly anticipate a big P. R. boost from this source. We predict wonderful success for this movement, and commend all who had the foresight to initiate it.

The radio and television have been used to a greater extent this year, particularly in Charleston. We are told that the reception of the various programs has been very gratifying. Pertinent newspaper items have also been released from time to time.

The Essay Contest was put on in the high schools again this year, in cooperation with the Association of American Physicians and Surgeons. The subject: "Why the Private Practice of Medicine furnished this Country with the finest Medical Care." The contest attracted more widespread interest this year and there was a considerably greater number of entrants than ever before. We are not at the time of this writing able to furnish numbers nor winners. It is our feeling that these contests are definitely worth while and have materially improved Public Relations.

We had a very attractive, well located Booth in the Steel Building at the State Fair, directly across from the Winthrop College display. It was manned by the ladies of the Auxiliary of the Columbia Medical Society and was well visited. We understand that there was much interest and many favorable comments. The Booth was also set up at the Florence Fair and manned by the ladies of the Florence Auxiliary; it was likewise well received there.

The Grievance Committee, which seems to be a must in all well organized Public Relations programs, functioned well during the year. Two cases were heard and there is one pending.

Our South Carolina Medical Care Plan, Blue Shield, has proven generally satisfactory to the Profession as well as the Insured and has therefore been a valuable contribution in the P. R. field.

Perhaps it should be mentioned here that the Legislative situation has been quite healthy; there does not seem to be any animosity toward the Profession in any quarter.

Perfect harmony has existed between the Association, the Medical College, and the State Board of Health.

The ladies of the Auxiliary have been found to be very cooperative, perhaps have cooperated in the Essay Contest this year to a greater extent than ever before.

In conclusion we wish to make two recommendations:

(1) That next year's P. R. Committee organize and hold a P. R. conference somewhat similar to the National Institute referred to at the outset of this report. All officers of the respective County Medical Societies to be invited and urged to attend; thereby familiarizing the group with the various P. R. Problems and perhaps offering some suggestions as to solution.

(2) Inasmuch as our very excellent Executive Secretary is not an experienced newspaper man, nor could he be expected to be, we feel that the Association should have a part time employee, versed in newspaper lingo, whose duty it would be to regularly release facts publicizing the innumerable acts the medical profession performs for the help and protection of the public and defending the profession against untrue accusations. We, therefore, recommend the employment of such a person.

The chairman of the committee wishes to express, in this report, his appreciation for the fine spirit of cooperation that has been shown by the members of the committee as well as the Executive Secretary.

W. Wyman King, M. D.
Chairman

COMMITTEE ON RURAL HEALTH

The Committee on Rural Health met in Sumter, S. C. on March 9th and discussed many ideas for the improvement of the rural health situation in our state. Dr. Johnston, chairman of the committee, had previously contacted numerous doctors over the state and their suggestions along with ours were discussed pro

and con.

It was the consensus of opinion of the committee that if the following ideas were carried out it would greatly improve rural health conditions.

- (1) Sewage disposal and good water supply made available for more densely populated areas especially in communities like Aiken, Travelers Rest, etc. where the population has greatly increased.
- (2) General need throughout the State for more beds for charity.
- (3) Do all possible to encourage men interested in Pediatrics, Internal Medicine, Ob. and Gyn. to locate in small communities where hospitals have been recently built.
- (4) General need for diagnostic work for the indigent.
- (5) The need for doctors to speak before lay groups or publish articles in rural newspapers to get across to the public the fact that we are doing all we can to give the best available medical care.
- (6) Attempt to increase the interest of the group in the lower income bracket through the various local agencies, namely, Farm Demonstration, Home Demonstration, and Farm Home Administration, in prepaid medical insurance, namely, Blue Cross and Blue Shield.
- (7) There was a general consensus of opinion of the men from the various sections of the State that the major portion of our job is counseling and educational, which requires time and patience of all groups involved.
- (8) That the scholarship offered by the State to medical students agreeing to practice in rural communities should be continued.

Respectfully submitted,
A. R. Johnston, M. D.
Charles R. May, M. D.
J. M. Brice, M. D.

COMMITTEE ON INFANT MORTALITY

This committee has met twice since the last meeting of the Association. Its activities have consisted largely of the consideration of various ways in which the importance of the care and salvation of premature infants might be impressed upon physicians, hospitals, and the public.

During the year there was sent to each hospital in the state a questionnaire asking about techniques and physical facilities for premature infant care. Reports from these questionnaires indicate some improvement over the figures secured several years ago. It is the desire of this committee to send this type of questionnaire, perhaps in briefer form, annually in order to stimulate interest in hospital staffs and superintendents.

The committee has also continued to send questionnaires to each physician who delivered or cared for a premature baby who died. Information from such questionnaires combined with what was obtained last year gives a fairly good picture of practices in the

state. Granting that these are not specific statistics and that they are subject to various interpretations, there seems to be a definite divergence in methods of handling the prenatal care and delivery of the premature infant, and in handling the infant after delivery, from the methods accepted and used in more metropolitan areas. The implication would be that diffusion of information to many of our physicians would be valuable in making some reduction of premature infant mortality.

The committee still finds difficulty in securing proper statistics because of the variable ways in which vital statistics are handled in various counties. A letter was written to each County Society suggesting the desirability of improvement, but no great result has been visible. There has been under consideration in the legislature a bill for establishing uniform methods of reporting, but it appears that it will not reach action this year.

The committee wishes to recommend highly the establishment of regular joint meetings of the obstetrical and pediatric staffs in the hospitals of the state.

This committee has no definite conclusions to make but feels that its efforts have created some interest in premature mortality. It realizes that its activity is largely educational and it hopes to continue its work with the endorsement of the Association. For this purpose, the committee would ask a renewal of the allotment of \$200.00 which was made to it last year.

The committee consists of Drs. Lee Sanders, Keith Sanders, Hervey Mead, John Bonner, Herbert Black, W. A. Hart, Ethel Madden, and J. I. Waring, Chairman.

ADVISORY COMMITTEE TO THE STATE BOARD OF HEALTH FOR THE DISTRIBUTION OF GAMMA GLOBULIN AND POLIO VACCINE

This committee was charged originally with consideration of the distribution of gamma globulin in the state for the purpose of modification or prevention of poliomyelitis. A meeting was held in Columbia with full attendance. A set of recommendations was drawn up and submitted to the State Board of Health and thereby to our members.

Later in the year this committee was appointed to act as advisors in the matter of trial of the Salk vaccine for poliomyelitis. Another meeting was held with the Staff of the State Board of Health and certain officials of the National Foundation for Poliomyelitis and the subject was discussed to the satisfaction of all concerned. As yet the vaccine has not been put into use.

Ben Miller	Walter Hart
Weston Cook	T. G. Goldsmith
Wyman King	J. I. Waring, Chairman

COMMITTEE ON HISTORICAL MEDICINE

The Committee asks that the Association recall the report of last year, in which it was pointed out that

there is now available to the Committee a reasonably large amount of material from which can be written a history of medicine in South Carolina, that some time will be required for preparation, and some amount of money will be required for publication. The Committee suggested the sum of \$3000,—as being necessary for preparation and eventual publication. Last year the Committee was granted \$500.00 for use toward the purpose of producing a history. A part of this has been expended, but most of it is on hand.

The Committee requests respectfully that the Association see fit to continue to add annual installments toward the estimated figure of \$3000.00, with the understanding that, if the project is not accomplished, the remaining funds will be returned to the Association.

Chapman J. Milling
R. M. Pollitzer
J. I. Waring, Chairman

COMMITTEE ON LEGISLATION AND PUBLIC POLICY

Your chairman attended the regional legislative conference in Atlanta scheduled by the American Medical Association's legislative committee on January 31, 1954. We listened to the position of the A. M. A. as regards: (1) System for Alerting Key Legislative Personnel; (2) Federal Subsidization of Private Health Insurance Plans; (3) Extension of Social Security Coverage to Include Physicians; (4) Permanent and Total Disability Insurance Under Social Security; (5) Waiver of Premium Payments Under Title II of the Social Security Act During Period of Permanent and Total Disability. Our small efforts went unrewarded, however, as one of the most favored by the group, the Jenkins-Keogh bill, was not included in the tax revision bill passed by the House and must be considered dead. The three percent medical deduction did pass, but on the whole most of the national legislation remained as it was. We were advised as to recommendations, particularly in approaching the law makers in Washington when medical legislation needs active support, or when unfavorable legislation needs opposition. South Carolina was well represented. Only one state in this area was not represented as they were having a medical meeting in reference to osteopathic legislation. Dr. C. Joseph Stetler, Secretary of Committee on Legislation of the A. M. A. presented a learned discussion of these bills, and conference co-chairmen, Dr. W. Clark Bailey of Kentucky and Dr. Reuben B. Chrisman, Jr. of Florida acted as moderators. The meeting started on time and ran through the day. A delightful dinner was served at the Academy of Medicine.

In South Carolina bill #1218, introduced by Sidney Duncan, considering a home for alcoholics is still in the Ways and Means Committee and will probably not be passed. Bill #1033, the Narcotics bill, was agreed to by the legislative committee of last year, after considerable change, but they were not enthusiastic. At present this bill is still in the Senate

Medical Affairs Committee and will also probably not be passed. The most active work that was done by the committee was offering opposition to bill #S504. This was "To create the South Carolina Board of Homeopathic Medical Examiners which shall consist of five members, four of whom are physicians of homeopathic schooling and members in good standing of the South Carolina Homeopathic Council. The fifth member shall be a medical doctor who shall be appointed by the Governor upon the recommendation of the State Board of Medical Examiners for a term of four years. The members of the board, other than the member recommended by the State Board of Medical Examiners shall be appointed by the Governor upon the recommendation of the South Carolina Homeopathic Council for terms of four years. The first members of the board shall be appointed within thirty days after the effective date of this act. The board shall meet within ten days after its appointment to formulate plans for the conduct of its business and to elect its officers." This bill, in your committee's opinion, was overlapping as we have ample, if not too many, boards at present. The medical profession was solid against this bill and both Dr. Hicks and Dr. Gaines went into action to aid with the opposition. We received help from many sources. Two societies passed resolutions against it. Letters went out from home town doctors to their senators, of which we received a few copies. The one from Dr. George Wilkinson is a classic. The committee felt the danger in this bill was as much in the fact that it could review diplomas from foreign medical schools as anything else. This was Article 2, section 14: "Graduates of foreign medical schools shall be admitted to the examination only after meeting such qualifications as the board may reasonably require." This bill overlapped the present medical board and as we did not license diplomas from foreign schools during the strenuous war and post war periods your committee cannot see the rationale of licensing them now when our own medical school is enlarging and when a curriculum continuing through the summer is being planned. This should in a relatively short time take care of our state needs amply, particularly since the pressure of the Army requirements is less.

The medical profession could accomplish anything reasonable and right if this same close, aggressive cooperation could be obtained in other matters as was shown against this bill.

David F. Adeock, Chairman
Committee on Legislation

BOOK REVIEW

MODERN CLINICAL PSYCHIATRY By Arthur P. Noyes, M. D., Philadelphia. The W. B. Saunders Company. Fourth Edition, 1953. Price \$7.00.

This is an extensive revision of a well-known text which has earned for itself the designation of "standard."

Doctor Noyes fits the familiar descriptive psychiatry into the modern dynamic concept, which happy union of the old and the new permeates the entire book. Thus a psychiatrist trained under the Kraepelinian school will not be lost in a maze of psychoanalytic concepts. On the other hand he will be brought in touch with the best of contemporary thinking. At the same time the neophyte will have his feet kept on the ground by plenty of objective description of symptoms.

The first six chapters are devoted to an introduction to abnormal psychology, with much emphasis on the newer dynamic theories. Chapter seven is an excellent systematic outline of how to examine a patient. From a practical viewpoint, however, the time required should this outline be followed literally, would be prohibitive for anyone but a resident with almost unlimited hours at his disposal.

Chapters eight to thirty-three, inclusive, deal with actual types, which have been made to conform to the new standard nomenclature. This nomenclature has been adopted by the American Psychiatric Association and will doubtless remain in use until a generation of students has been trained in its mysteries, after which, assuming that history may be expected to repeat itself, another and yet more complicated nomenclature will be adopted.

A chapter each has been devoted to Child Psychiatry, Shock and other Psychical Therapies and Psychotherapy.

There is an adequate index and to each chapter a rewarding bibliography has been appended.

Modern Clinical Psychiatry is a solid book which is not intended for light or easy reading, but which will be of manifest help to the serious student.

Chapman J. Milling



DEATHS

DR. SARAH C. ALLAN

Dr. Sarah Campbell Allan, South Carolina's first woman physician, died at her residence, 19 Gadsden St., Charleston.

Dr. Allan was born in Charleston December 7, 1861, a daughter of the late James and Amey Sarah Hobb-croft Allan.

She had attributed her becoming a physician to the encouragement given by her father in overcoming the then existing beliefs that it was not a woman's field. Her father was founder of the King Street jewelry store which bears his name.

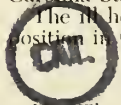
Dr. Allan received her degree from the Woman's Medical College of New York Infirmary in 1894. This school was later amalgamated with the medical department of Cornell University.

A year later she became an assistant to the late Dr. J. W. Babcock at State Hospital in Columbia. She remained in Columbia until May, 1907. During this period she administered to 500 women.

Dr. Allan also studied medicine under Dr. Elizabeth Blackwell, first woman physician in this country. After receiving her degree, she attended Johns Hopkins University.

She had the highest grade among that group of doctors who stood the examinations of the South Carolina State Medical Board when she did.

The ill health of her father caused her to resign her position in Columbia in 1907 and return to Charleston.



DR. T. M. STUCKEY

Dr. Theodore Malcolm Stuckey, 68, died at the Bamberg County Memorial Hospital following a few days' illness.

Dr. Stuckey, born near Bishopville, was educated at Welsh Neck (old Cokesbury College near Greenville). He attended the University of Tennessee and was graduated from the Medical School of the University of Alabama. Following graduation, he practiced medicine at Lineville, Ala. He then moved to Cope where he resided until he came to Bamberg 25 years ago.

Besides his large practice, he had extensive farming interests. He was a member of Trinity Methodist Church, a member of the Bamberg County Hospital staff, the Tri-County Medical Association, the South Carolina Medical Association and the American Medical Association.

DR. HENRY DEAS

Dr. Henry Deas of Boone Hall Plantation died at a local infirmary after a long illness.

Dr. Deas was born in Camden, April 18, 1892, a son of James Douglas Deas of Camden and Mrs. Camilla C. Richardson Deas of Clarendon County.

He was graduated from the Medical College of the State of South Carolina in 1914. He served his internship and residency at the Baker Memorial Sanatorium.

Since his affiliation with Baker he had been a general practitioner and surgeon here, except for several years service with the Army Medical Corps in World War I.

He was a member of the Charleston County Medical Society, the South Carolina Medical Society and a past member of the American Legion Post No. 10. He was a member of Grace Church.

DR. W. C. ROGERS

Dr. Wilson Chalmers Rogers, 67, physician of the Indiantown community, Williamsburg County, died at his home Monday afternoon after a short illness.

He had been in declining health for several years.

Dr. Rogers was born January 22, 1887, a son of the late Melvin Wilson and Mattie Barr Rogers, both of Indiantown. He attended Davidson College, the College of Charleston and was graduated from the Medical College of South Carolina, Charleston, in 1912. After graduation, he practiced medicine in the Dunbarton community for two years, then returned to his home at Indiantown. He practiced medicine here until the day of his death.

He was a member of the County and State Medical Associations and had held offices in both organizations. He was a World War I veteran and was a member of Williamsburg Post No. 8, American Legion, at Kingstree. He was a lifelong member of Indiantown Presbyterian Church and participated in both church and civic activities.

DR. E. H. SPARKMAN

Edward Heriot Sparkman, Jr., Captain, U. S. N., retired, Charleston, S. C.; born in Charleston, S. C., January 22, 1880; Medical College of the State of South Carolina, Charleston, 1904; fellow of the American College of Surgeons; member of the South Carolina Medical Association; formerly on the faculty of his alma mater; for four years assistant visiting surgeon at the Roper Hospital; in September, 1916, appointed an assistant surgeon, National Naval Volunteers, U. S. N., and was serving as a lieutenant commander, Naval Reserve Force, at the time of his release from active duty in September, 1919; requested and was ordered to active duty in 1921; later transferred to the Medical Corps of the regular Navy with the rank of lieutenant; promoted to Captain, Medical Corps, U. S. N. in June, 1942; transferred to the retired list of officers February 1, 1944; retained on active duty until October, 1945; a veteran of World Wars I and II and of more than 30 years of Naval service; served at the Naval hospitals, Charleston, S. C., Canacao,

P. I., Norfolk, Va., Mare Island, Calif., at the Naval Academy, Annapolis, Md., with the First Marine Brigade, Port Au Prince, Haiti, and in the U. S. ships, Seattle, Patricia, Barker, Mersey, Hatfield, Dobbin, Milwaukee, and Melville; died January 21, aged 73.

NEWS ITEMS

A group of friends and ex-patients of Dr. William Atmar Smith of Charleston have provided a portrait which has been hung in the new Pinchaven Sanatorium.

Dr. R. A. Howell is going to take up the practice of internal medicine in Bennettsville.

Drs. William and Jerry Perry have moved into the new Clinic building in Chesterfield.

ALL OBLIGATED PHYSICIANS DUE FOR ACTIVE SERVICE BY JULY 1, 1955

During the next fiscal year, starting next July 1, the Defense Department expects that all hospital interns and residents obligated for military service will have to be called to active duty. However, according to Assistant Secretary Berry, the demand may not be as heavy during the first half of the period, due to a backlog of 1953 medical school graduates and a small number left over from Priority I. For the men facing almost inevitable calls, Dr. Berry urges hospitals to make short-term arrangements so they "will have a means of livelihood and also the opportunity to continue their education, as well as to contribute to the needs of the hospitals," while awaiting orders the last six months of this year and the first six months of next.

AMA Washington Letter

The Medical Library Association will hold its Fifty-third Annual Meeting June 15-18, 1954, in Washington, D. C. The headquarters will be the Hotel Statler, and the official host the Armed Forces Medical Library.

The program will include a discussion on medical research by embassy attaches, tours of the National Institutes of Health, the National Naval Medical Center, and of the Armed Forces Medical Library.

The Nalle Clinic Foundation will present two lectures at the Hotel Barringer, Charlotte, North Carolina, on the afternoon and evening of Friday, April 23, 1954.

The afternoon lecture will be given by Dr. Harry Dowling, Professor of Medicine at the University of Illinois College of Medicine. His subject will be "Recent Advances in Antibiotic Therapy."

The evening lecture, which will be the Fifth Brodie C. Nalle Lecture, will be given by Dr. Robert A. Kimbrough, Jr., Professor of Gynecology and Obstetrics in the Graduate School of Medicine of the University of Pennsylvania. The topic of Dr. Kimbrough's lecture will be, "Management of the Hemorrhages of Pregnancy."

The Fairfield County Medical Society held the monthly meeting at the Fairfield Inn, Thursday, March 4th. Dr. W. R. Wallace of Chester was the guest speaker and gave a very informative talk on hospital management. Present also as a guest was Mr. R. Harris McDonald, chairman of the Fairfield County Hospital Board. Announcement was made that the new hospital in Winnsboro would open about July 15th. Dr. C. S. McCants was host for this meeting.

DR. PRICE SPEAKS TO MEDICAL GROUP

Dr. Julian Price of Florence, member of the Board of Trustees of the American Medical Association and representative on the Joint Board of Hospital Accreditation, spoke to the Active and Courtesy Medical staffs, the Board of Trustees and a group of hospital department heads of Conway Hospital at a dinner at Bob's Grill recently.

Dr. V. J. Hyams is moving to Bethune where he will practice general medicine. Dr. Hyams, who has been practicing medicine in Kershaw for the past three years, said that the move would be effective in the near future.

TRI-STATE SOCIETY

Dr. Frederick E. Kredel of Charleston was elected president and Dr. Paul D. Camp of Richmond was elected president-elect. Elected vice presidents were Dr. A. A. Dreesy of Newport News, for Virginia; Dr. Fred Merritt of Greensboro, for North Carolina; and Dr. J. E. Crosland of Greenville, South Carolina.

Elected to the board for three years were Dr. Henry Langston of Danville, Dr. John R. Bender of Winston-Salem, and Dr. C. S. McCants of Winnsboro, S. C., who will serve his second term.

Dr. R. B. Davis of Greensboro was reelected secretary-treasurer for three years. He also will serve as editor of the organization's medical journal.

The group voted to meet next year at Ft. Monroe, Va.

Dr. William R. Speaks of Leesville, formerly of Fairfax, who was elected recently as president of the Medical Society of the Second District of South Carolina, was graduated from the Medical College of South Carolina in 1951, and was president of the senior class. Then he interned at the Columbia Hospital.

GAFFNEY

Dr. Clyde Graham Hopper, Jr., son of Mr. and Mrs. Clyde G. Hopper, of South Petty Street, will enter the private practice of medicine there March 1.

Dr. Hopper comes here from Columbia where he has been a resident physician at the Columbia Hospital of Richland County. He will be associated with Dr. W. K. Brumbach and will share Dr. Brumbach's office building on North Granard Street.

Dr. Joe A. Stewart, a native Fountain Inn boy, will be associated with Dr. Walter McLawhorn in the McLawhorn-Stewart Clinic.

Dr. Stewart attended Clemson College and received his medical degree from the University of Oklahoma and interned in the Baroness Erlanger Hospital in Chattanooga, Tenn.

Clough Wallace, M. D., has recently been certified by the American Board of Proctology as a full Diplomate.

Dr. Robert D. Hicks and family moved to St. Matthews.

Dr. Hicks, who moved from Bishopville, was born in Florence and is the son of the late Dr. N. W. Hicks of that city. He attended Florence High School and received a B. A. Degree from Duke University in 1934.

The Darlington County Medical Society held its first meeting of the year and elected officers for the ensuing year: President, Dr. Barney Timmons; Secretary-Treasurer, Dr. A. P. Rosenfeld; Delegate to the State Meeting, Dr. E. M. Gunn.

Members of the Fairfield County Medical Association were guests of Dr. C. S. McCants at a recent din-

ner meeting at the Fairfield Inn, where covers were laid for eight.

Dr. W. R. Wallace of Chester, an ex-president of the South Carolina Medical Society, and the guest speaker, gave a talk on "Hospital Management."

ANDERSON

The care of charity patients was one of the main subjects of discussion at a meeting of the Anderson County Medical Society recently.

A plan was proposed for further study concerning the establishment of an out-patient clinic for charity patients not requiring hospitalization. Under such a plan, the clinic would make use of the hospital's laboratory and X-ray facilities with physicians giving their time. A fund to provide medication for charity patients was also discussed.

The diphtheria situation in the county was discussed by Dr. Grady Callison, who discounted an epidemic.

One new member, Dr. E. H. Miller of Belton, an associate of Dr. W. L. McIlwaine, was admitted to the Society.

Elected to the Board of Censors (credentials committee) were Dr. J. B. Latimer and Dr. Claude Prestov. They will serve with Dr. E. B. Stoudemire of Honea Path.

Dr. W. C. Bolt is president of the Medical Society.

ST. GEORGE

Dr. E. J. Bogen of Columbia plans to open an office in St. George in the near future. He will have his office in the Bryant Building on Main Street, across from the Post Office.

Doctor Bogen, a native of Denmark, S. C., has practiced medicine for the past 15 years.

DR. CLOUGH BLAKE

For his outstanding service to the community of Greenwood, Dr. Clough H. Blake has been awarded the Rotary Club's "Man of The Year" plaque.

The award was announced at the Club's annual Ladies' Night dinner meeting at the Oregon Hotel last night. In the absence of Dr. Blake, who was unable to attend because of ill health, a plaque was presented to his daughters, Mrs. Henry Crigler, Jr. and Miss Elma Blake.

Rotarian Howard Burns made the presentation.

"No man in Greenwood is more deeply respected or more universally liked. His ability and integrity have earned him many honors from his colleagues in his profession—his kindness and gentility, the love of all who know him.

"He has never let hard work for his community, or for the profession in which he has spent his life, obscure his wonderful sense of humor or blur his keen perceptiveness.

"He is an aristocrat in the true sense of the word, of whom it can be said he is 'elegant without artifice, witty without unkindness, humorous without prolixity, and modest without poverty of spirit.'

"He is our good friend and a great man, and we honor ourselves in recognizing him this evening—Rotary's Man of The Year—Dr. Clough H. Blake."

FLORENCE

McLeod Infirmary officials last night said the hospital has a guarantee on a \$350,000 loan for the construction of a new Negro wing for the hospital.

The actual loan depends on a three-party agreement, no parts of which have been settled. Mark Stanton, hospital administrator, and Dr. Walter R. Mead of the hospital staff, said the loan will depend on agreement between the Reconstruction Finance Corporation, the Guaranty Bank and Trust Co. here and the Board of Trustees of the hospital.

Stanton said approval from the RFC committed the

federal government to a guarantee of 90 per cent of the loan if the loan is approved by the Florence bank.

The next step is the approval of all three interested organizations and the settlement of terms.

CAMDEN

Work has recently begun on a new, \$24,813 physicians' office building, which will soon rise on Walnut Street near its intersection with Little Street.

Owners of the structure will be Drs. George and Carl West, who will maintain offices there.

The building will be of brick and concrete block construction, a building permit on file at city hall indicates.

BATESBURG

Dr. Marvin H. McLin of Batesburg has been elected president of the Batesburg-Leesville Chamber of Commerce by the board of directors.

CHESTER

Dr. W. R. Wallace addressed the County Medical Society at its February meeting at the County Hospital with the president, Dr. M. L. Marion, presiding. Dr. Wallace's subject was "Medical History of a Century or More Ago."

The speaker told of the medical history of the pioneer days. Among his exhibits was a medical microscope, which was one of the type brought to this nation in its pioneer days.

Dr. Wallace also exhibited historically rare and valuable bound copies of medical journals published in 1762 to 1763, approximately two centuries ago, disclosing the manner of the treatment of diseases and illnesses of those days.

ANNUAL MEETING OF THE

SOUTH CAROLINA HEART ASSOCIATION

The fifth annual meeting of the South Carolina Heart Association was held this year at the Greenville General Hospital in cooperation with the Greenville County Medical Society on February 1. At the Business Meeting of the association Dr. John A. Boone, of Charleston, President of the association since its founding in 1948, was elected Chairman of the Board of Directors. Dr. William Schulze of Greenville, was elected President for the year 1954. New members of the Board of Directors are Dr. Allen B. Warren, Jr., of Spartanburg, and Mr. Nat W. Cabell, of Charleston. A visitor at the meeting was Mr. Jerome Baker, Program Consultant of the American Heart Association, who described methods of increasing the membership and public interest in the State Heart Association. It was emphasized that membership in the State Heart Association includes membership in the national organization and is open to any physician or layman who is interested in contributing toward the work of the association. Application for membership may be made by sending the annual dues of \$5.00 to Mr. H. M. McElveen, Executive Secretary of the South Carolina Heart Association, 203 Carolina Life Building, Columbia.

The scientific session, which was attended by approximately 300—most of them physicians, was held at the Greenville General Hospital, and a number of prominent out-of-state speakers were heard.

Dr. Robert T. Grant, who is at present a member of the National Heart Institute at Bethesda, Maryland, is one of the leading exponents of the new development in electrocardiography, which has been named vectorcardiography. This is a method derived from the various leads of the ordinary electrocardiogram of combining the deflections in two or more leads arithmetically to demonstrate graphically the various directions taken by the net electromotive force of the heart beat during the whole of the cardiac cycle. Dr. Grant

and others interested in vectorcardiography, maintain that it is a simplification of electrocardiography and that all the leads of the usual electrocardiogram can be reconstructed from a vectorgram, which contains in a single illustration all the information derived from multiple electrocardiographic leads. He had many tracings made before and after coronary thrombosis in a large series of cases and showed that in addition to the Q wave changes, to which most attention has been paid in routine electrocardiography, there are also S wave changes which may well be of equal significance when presented by vector methods.

Dr. Elliott V. Newman, who is Professor of Experimental Medicine of Vanderbilt University, discussed many of the problems involved in diuretic therapy—pointing out what a complicated subject it really is and offering explanations for the failure of some diuretics to work when others will in the same case. He pointed out that most of our diuretic methods accomplish their purpose by forcing the excretion of sodium, whereas the fundamental problem is to get rid of water. He showed that in many cases the loss of sodium had a deleterious effect which counterbalanced the benefit from secondary loss of water with it, and how in such cases diuretics which effectually remove water without going through the mechanism of sodium loss may be more effective and free of excessive electrolyte depletion. He also gave a philosophical discussion of cardiac failure, showing that it is not easily defined in a few words but is a rather complex series of changes secondary to reduced efficiency of the heart beat. With this concept much of the confusion resulting from the concepts of high output and low output failure disappears and it is seen that both are manifestations of the same loss of efficiency of the heart as a whole and have more differences in etiology than in fundamental mechanism.

Dr. Harold Feil, Clinical Professor of Medicine at Western Reserve University, gave an interesting discussion of the development of our present concept of coronary artery disease and an excellent and sensible summary of present day treatment. At the evening meeting he gave a similar after-dinner talk, describing the development of our knowledge of congenital heart disease and the surgical treatment of it, both of which belong to very recent years. He has promised a condensation of his paper on coronary artery disease for separate publication in an early issue of the Journal.

At the morning meeting Dr. H. William Scott, Jr., the new Professor of Surgery at Vanderbilt, gave a report on a most ingenious series of experiments designed to investigate the cause of hypertension in congenital coarctation of the aorta. It had previously been assumed that this was merely a mechanical effect from the narrowing of the aorta between the origins of the arm and leg arteries, and recent experiments by physiologists have appeared to support this view. However, Dr. Scott was able to show conclusively that the hypertension was a response to renal ischemia induced by the coarctation. By transplanting the kidney to the neck of the experimental animal, and then producing experimental narrowing of the aorta, he was able to show that immediately after the narrowing was produced the blood pressure in the upper extremity rose promptly but after a few hours fell back to the preoperative level. Over a period of weeks if a kidney remained below the coarctation the animal's blood pressure in the upper extremity then steadily rose and permanent hypertension then ensued, but disappeared when the remaining kidney was removed. If both kidneys were first removed and one transplanted to the neck, hypertension in the upper extremity did not develop after coarctation was produced. Evidently, then, the hypertension in coarctation of the aorta is a perfect example of the Goldblatt kidney, which has been familiar for many years. At

the evening Banquet session, Dr. Scott described his experiences with performing cardiac surgery with the patient's body temperature cooled to approximately 25° Centigrade, which allows the inflow and outflow of blood from the heart to be clamped off for a few minutes while intracardiac surgery is performed without the usual irrevocable damage to vital organs which occurs when the circulation is stopped at normal body temperatures. Dr. Scott regards hypothermia in cardiac surgery as a useful procedure while we are waiting for the development of successful mechanical hearts, but it has many disadvantages which will probably prevent it becoming more than a useful adjunct to other methods.

Dr. Leslie B. Hohman, Professor of Neuro-Psychiatry at Duke, gave a most interesting talk on the psychiatric aspects of heart disease. He had little to say on the very common complication of cardiac neurosis seen by all physicians, but was more concerned with the truly psychotic manifestations incident to cardiovascular disease. He emphasized that electroshock therapy may be safely used in nearly all patients with congestive heart failure and may frequently be lifesaving in those who are exhausting themselves with excessive physical activity incident to their disturbed state. He emphasized that the chief danger was in those with coronary artery disease.

Dr. J. Willis Hurst, Associate Cardiologist of Emory University in Atlanta, gave a detailed description of the peculiarities of heart failure in children. What made

his talk most interesting is that he is an internist and had to learn these peculiarities the hard way so that he was able to emphasize the marked differences in the behavior of children with heart failure and our ordinary concepts of heart failure in adults. Of particular interest to the writer was his statement that the diagnosis even of heart failure in infants and young children is often missed; especially because the patient cannot describe his shortness of breath and because he is much more likely to develop an enlarged liver and ascites than he is to have pleural effusions and peripheral edema. We have only recently realized that infants require more digitalis per unit of body weight than adults. Moreover infants are more apt to develop heart failure from varieties of infectious diseases and other diseases of unknown etiology and are more subject to prolonged tachycardias which result in congestive failure. He had an interesting demonstration of the difficulty of estimating the size of an infant's heart by x-ray, showing that the phase of respiration when the exposure is made may make the same heart look either normal sized or grossly enlarged.

Everyone who attended seemed to feel that it had been a very informative and worthwhile meeting. It was agreed that the next annual meeting would be held in Charleston at a time to be announced later and all physicians in the state are cordially invited to attend it.

John A. Boone, M. D.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. David A. Wilson, Greenville, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

CONVENTION PLANS ANNOUNCED MAY 11, 12, 13

The 29th Annual Meeting of the Woman's Auxiliary to the South Carolina Medical Association will be held at Myrtle Beach on May 11, 12, 13, with headquarters at the Ocean Forest Hotel. All business meetings will be held at the hotel.

The House of Delegates will convene at 9:30 on Thursday, May 13, followed by the program meeting at 11:30. Mrs. George D. Feldner will bring greetings from Southern, and Mrs. Leo J. Schaefer of Salina,

Kansas, President of the Woman's Auxiliary to the American Medical Association, will be the guest speaker at this meeting. At 1:30 there will be a Dutch Membership luncheon for all auxiliary members, who may secure tickets when they register for the convention. The luncheon will be held at the Pine Lakes Country Club and Inn. The tickets will be \$3.00.

The doctors will entertain their wives at a banquet on Thursday evening at 8:00 at the Ocean Forest Hotel, which will close the convention.

SEE YOU AT MYRTLE BEACH

NUTRITION

DIETS FOR PATIENTS WITH HEART DISEASE

Low Calorie Diets:

It stands to reason that the overweight patient puts extra work on his heart, hence the importance of weight loss for obese patients with heart disease. Although doctors are thoroughly convinced of this, it is often hard to persuade the patients that they should reduce. Dyspnea on exertion and edema of extremities may often be corrected by weight reduction.

Usually no diet of less than 1000 calories is prescribed as it is felt that it is impossible that a more restricted diet be adequate and palatable. A vitamin supplement should be used with this diet. 1200 calorie and 1500 calorie diets are often used, depending on the degree of obesity.

Low Sodium Diets:

The 200 mg. sodium diet is often used for patients with hypertension who are on low calorie diets. 200 mg. or 400 mg. sodium diets are used for patients with congestive heart failure. We have had good success in getting patients to adhere to these diets, especially if there is any tendency to edema. The food can be made quite palatable with salt substitutes, pepper, dry mustard, onions, garlic, vinegar, lemon juice, etc. Sometimes it is hard to make the patients realize that "low sodium" means restriction of soda, baking powder, Epsom salts, etc., besides salt in foods.

It is not necessary to buy many special low sodium foods. Low sodium bread or low-sodium baking powder to make bread are not very costly. If there is no economic problem, low-sodium canned vegetables add more variety to the diet, and certain herbs make the food more palatable. With a bit of ingenuity and the help of recipes, there is no reason why the low sodium diet need be drab and tasteless.



*Through its probable action on the labyrinth,
dependable control of vertigo and nausea has made
Dramamine the most widely-prescribed product in its field.*

Vertigo: The Labyrinthine Structure and Dramamine®

Dramamine's remarkable therapeutic efficiency is believed to be the result of suppression of the over-stimulated labyrinth. Thus it prevents the resulting symptom complex of vertigo, nausea and, finally, vomiting.

First known for its value in motion sickness, Dramamine is widely prescribed for nausea and vomiting of pregnancy, electroshock therapy, certain drugs and narcotization. It relieves vertigo of Ménière's syndrome, fenestration procedures, labyrinthitis, hypertensive disease and that accompanying radiation and antibiotic therapy.

A most impressive number of clinical studies shows that Dramamine has a high therapeutic index and minimal side actions. Drowsiness is possible in some patients but in many instances this side action is not undesirable.

Dramamine (brand of dimenhydrinate) is available in tablets of 50 mg. each; liquid containing 12.5 mg. per 4 cc. Dramamine is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

Low Cholesterol Diets:

Low cholesterol diets are not being used in the cardiac clinic. At the present time, it is felt that they have not been proven in effectiveness for coronary heart disease, either in prevention or cure. Much research is being done and there may come a time when the average diet is revolutionized to the extent that it will be much lower in vegetables and animal fats, throughout the entire life span, as a preventive measure.

Some Good Sources of Diet Materials:

1. "Food for your Heart," (Booklet), South Carolina

Heart Association, Inc., Columbia, S. C.

2. "Overweight and Underweight," (Booklet), Metropolitan Life Insurance Company.
3. Simple 200 mg., 400 mg., and combination low sodium—low calory diet lists, Cardiac Clinic, Medical College, Charleston, S. C.

For up-to-date information on diets at any time, write the American Dietetic Association, 620 N. Michigan Avenue, Chicago 11, Illinois.

J. A. Boone, M. D., Director

Margaret Freeman, Dietitian

Cardiac Clinic, Medical College of South Carolina

WHITTEN VILLAGE

B. O. Whitten, M. D., Superintendent
Clinton, S. C.

Institution with above title has good position to offer as Clinical Director to young, capable physician, preferably a South Carolinian but not necessarily. Person logically succeeds to Superintendency in few years, or refuses that office at his discretion. Anyone interested, communicate with the undersigned.

B. O. Whitten, M. D.
Superintendent

ESTES SURGICAL

SUPPLY COMPANY

Phone Walnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

WHOLESALE FURNITURE

By special arrangement we are able to offer Doctors of the South Fine Furniture at a Wholesale Price. If you would desire the latest issue of our wholesale catalog, simply drop us a post card giving your name and address. Our Catalog contains a selection of fine furniture for every room in the house.

We have available at wholesale most of the nations best furniture. Therefore, we invite you to send us your requirements other than those pictured in our catalog. We can fill almost any orders for really good furniture.

Our firm is a division of the CULLERS HALF ACRE of Aiken, S. C. (two miles out on Augusta Highway), and the Jackson Furniture Company of North, S. C. You are invited to visit our showrooms at either of these locations.

CULLER-JACKSON WHOLESALE FURNITURE CO.

DRAWER "C"

NORTH, SOUTH CAROLINA



Founded 1927 by Charles A. Reed

Member of American Hospital Association

Florida Hospital Association

American Psychiatric Hospital Institute

Miami Sanatorium Serves all Florida and the Federal Agencies

Information on Request

NORTH MIAMI AVENUE AT 79TH STREET
Miami, Florida

Phone: 7-1824
84-5384

NEUROLOGY INSTITUTE

For Diagnosis and Treatment of Nervous and Mental Disorders, Alcoholism and Drug Habituation

The Journal

of the

South Carolina Medical Association

VOLUME L

May, 1954

NUMBER 5

Arteriovenous Aneurysm of The Brain

Report of a Case Treated by Total Excision

LUTHER C. MARTIN, M. D.^{*} AND JOSEPH V. JEFFORDS, M. D.

Arteriovenous aneurysms of the brain were once considered a rare lesion.

However, in recent years, since the development of cerebral angiography, these lesions have been recognized with much greater frequency. Dandy¹ remarked that these lesions occur in about 0.5 - 1.0 per cent of cases in clinics where neurological material is concentrated. However, with the recent use of cerebral angiography, some neurological clinics² report an incidence of as high as 1.8 per cent of arteriovenous aneurysms among the neurological cases.

The most frequent symptom of arteriovenous aneurysms is the epileptic seizure. This occurs in about half of the cases. These seizures are often focal in character, occasionally spreading in the typical Jacksonian march from the site of origin. The second most frequent symptom is subarachnoid hemorrhage. The incidence of intracerebral hemorrhage is also fairly high with these lesions. It is this rather high incidence of bleeding which causes the high mortality with arteriovenous malformations. In a recent review by Allegre and Walker,³ a review of 313 cases of proved spontaneous subarachnoid hemorrhage revealed that 40.2 per cent of the patients died in the initial attack. Of those surviving, 36.3 per cent died in the second attack. Of the remainder of the patients, 28.1 per cent died in the third or a subsequent attack. The mortality was greatest in the first week following hemorrhage, 35.4 per cent dying in this period. It has also been reported by several observers that a

second hemorrhage occurs within two or three weeks after the initial hemorrhage in about two-thirds of the cases. This is a very significant observation when the time for treatment of these lesions is considered.

Other less frequent symptoms of arteriovenous aneurysms are headache, papilledema, and exophthalmos. There is also a fairly high incidence of slight to moderate mental changes in these patients. These mental changes are secondary either to destruction of the brain by hemorrhage or to atrophy following numerous epileptic seizures. Bruits may be heard occasionally over the cranium of the patients. However, the occurrence of a bruit is not pathognomonic of arteriovenous aneurysms, as it can also occur in saccular aneurysms and vascular tumors.

X-ray studies are of great value in the diagnosis of these lesions. There are often changes in the skull secondary to the increased vascularity, causing increased or abnormal vascular markings. In a small percentage of cases there is also evidence of calcium deposits, either around the abnormal vessels or in the site of an old clot. However, by far the most important study is cerebral angiography. This procedure was introduced in 1927 by Egas Moniz.⁴ Since that time the procedure has been greatly improved and simplified. With the development of less toxic radio-opaque solutions, the incidence of complications from this procedure has diminished. The majority of the cases now can be done under local anesthesia, injecting the radio-opaque material percutaneously into the common carotid artery or the vertebral artery. The contrast material used in most cases is 35% Diodrast. Not only

^{*} Instructor in Neurosurgery. From the Department of Surgery (Neurosurgery), Medical College of South Carolina.

are the cerebral angiograms very valuable in the diagnosis of the lesions, but they are equally valuable in planning the surgical attack upon the lesion. It is of great importance to know what arteries supply the lesion, the size of the lesion, and what veins drain it, before an operative attack is made.

The treatment of arteriovenous aneurysms of the brain has changed completely in the past 10 to 20 years. Cushing and Bailey⁵ and Dandy⁶ considered these lesions practically inoperable. They recommended decompression and X-ray treatment in most cases. However, with the recent development of more accurate diagnosis with cerebral angiography, the development of newer surgical techniques, and the use of controlled hypotension during the surgery, many neurosurgeons now feel that these lesions should be given the benefit of radical surgical removal. However, the number of reported cases of successful removal of arteriovenous aneurysms is rather small. The largest series is that of Olivecrona and Riives,² but there are other reports by Penfield and Erickson,⁷ Pilcher,⁸ Dott,⁹ and Bassett.¹⁰ Unless there are objective findings of progressive neurological deficit, uncontrolled convulsions, severe pain, or recurrent intracranial bleeding, active surgical attack is not usually recommended.

The following case represents an arteriovenous aneurysm in the right frontal lobe which was completely removed surgically. This case demonstrates some of the previously-mentioned points in the diagnosis and treatment of arteriovenous aneurysms.

Case 1. S. M. A 24-year-old white female was admitted to Roper Hospital on November 7, 1952 with a history of a sudden onset of severe headache. This headache was not localized and became progressively more severe. Following immediate admission to the hospital patient became very irritable and at times incoherent. She later became drowsy and difficult to arouse for examination. No history of previous similar attacks. Family history negative.

The physical examination on admission revealed a very drowsy young white female who would respond slightly to questions but was not very cooperative for examination. There was no bruit heard over the skull. The neck was moderately stiff to flexion. The pupils were small, round, and equal in reaction to light. The optic discs were blurred bilaterally and the left disc was elevated about two diopters. There were no retinal hemorrhages. Movements of the eye were normal, as well as the visual fields to confrontation. There was no motor or sensory loss. The deep tendon reflexes were equal and active throughout. There were equivocal bilateral Babinski reflexes. B. P. 125/80.

A spinal tap was done on admission which revealed grossly bloody spinal fluid under increased pressure, about 400 mm. of water. Only a small amount of fluid was withdrawn.

As soon as it was obvious that the patient had a subarachnoid hemorrhage she was placed on absolute bed rest, with sufficient sedatives to keep her absolutely quiet. The headache persisted for one week and the patient also developed a very stiff neck and marked photophobia. The spinal puncture was repeated after a week in the hospital. At this time the fluid was xanthochromic, under an opening pressure of 250 mm. of water.

On November 18, 11 days after admission, a cerebral angiogram was done by percutaneous injection of the right carotid artery. These studies revealed a mass of blood vessels, an arteriovenous aneurysm or fistula,



Figure 1. Lateral Cerebral Angiogram; Arterial Phase. Note arteriovenous aneurysm at frontal pole, with large arterial branch of anterior cerebral artery supplying the lesion.



Figure 2. A.-P. Cerebral Angiogram; Late Arterial Phase. Note arterial supply from anterior cerebral artery on medial aspect of frontal lobe.



Figure 3. Lateral Cerebral Angiogram; Venous Phase. Note the two large veins arising in the lesion and draining into the sagittal sinus.

in the right frontal lobe at its anterior, inferior, and medial margins. (Figures 1, 2, and 3). The arterial supply was derived primarily from branches of the anterior cerebral artery. The venous return was primarily through two large veins draining into the superior sagittal sinus.

On November 25 a right frontal osteoplastic craniotomy was done. Prior to this procedure the internal carotid artery was exposed in the neck for control of the intracranial bleeding. When the dura was opened a large mass of blood vessels was found covering the entire tip of the frontal lobe. (Figure 4). There was red arterial blood entering several of the very large veins which drained the lesion. The brain was retracted laterally at the midline and several branches of the anterior cerebral artery were identified, clipped, and coagulated. The anterior two inches of the frontal lobe was then slowly removed by use of the electro-



Figure 4. Drawing of Arteriovenous Aneurysm as seen at operation. Note the large veins draining the lesion.

scalpel and blunt dissection. The arterial branches feeding the lesion were isolated and clipped. After all of the efferent arteries had been clipped, the mass of blood vessels comprising the lesion and the afferent veins completely collapsed. The draining veins were then clipped and coagulated.

Postoperatively the patient made a rapid recovery. The neurological examination remained within normal limits. There were typical symptoms usually seen after frontal lobectomy, such as loss of inhibition, talkativeness, loss of abstract thought and euphoria. The patient was discharged 10 days after operation.

The patient has now been followed for a period of 16 months. Her frontal lobe symptoms have completely disappeared and the neurological examination is completely within normal limits. There have been no seizures, and rarely a headache. As best as can be determined by the patient's husband, there have been no residual changes in personality.

Discussion.

The symptoms of recurrent convulsive seizures, particularly focal in nature, occurrence of subarachnoid or intracerebral hemorrhage, particularly in a young person, should arouse one's suspicion of an arteriovenous aneurysm. In cases in which there is a subarachnoid hemorrhage, angiography should be carried out within the first two weeks if possible, due to the high percentage of recurrence of the subarachnoid bleeding. If the lesion as demonstrated by angiography appears to be operable we believe that radical operative removal is the treatment of choice. If the lesion is considered inoperable, conservative treatment, such as bed rest, X-ray therapy, and limitation of activity is necessary. However, in spite of strict adherence to these measures, the incidence of recurrence of intracranial bleeding, and thus the mortality, is high. The value of carotid artery ligation and of X-ray therapy in these lesions is of questionable value. Thus, patients having these formidable lesions should, if possible, have the lesion completely removed.

1. Dandy, W. E., Arteriovenous aneurysm of the brain. *Arch. Surg.*, 17:190-243, 1928.
2. Olivecrona, H. and Riives, J., Arteriovenous aneurysms of the brain, their diagnosis and treatment. *Arch. Neurol. & Psychiat.*, 59:567-603, 1948.
3. Allégre, G. and Walker, A. E., Biological Course of Spontaneous Subarachnoid Hemorrhage. *Trans. of Phila. Neurological Society*, Feb. 6, 1953.
4. Moniz, E., L'encéphalographie artérielle, son importance dans la localisation des tumeurs cérébrales. *Rev. Neurol.*, 2:72-90, 1927.
5. Cushing, H. and Bailey, P., Tumors arising from the blood-vessels of the brain. Angiomatous malformations and hemangioblastomas. Springfield, Ill., Charles C. Thomas, 1928, X, 219 pp.
6. Dandy, W. E., The brain. *Lewis Practice of Surgery*. Hagerstown, Md., W. F. Prior Co., Inc., 1932, 12:1-682. (See p. 433).
7. Penfield, W., and Erickson, T. C., Epilepsy and cerebral localization. A study of the mechanism,

- treatment and prevention of epileptic seizures. Springfield, Ill., Charles C. Thomas, 1941, X, 623 pp. (See pp. 168, 254).
8. Pilcher, C., Vascular anomalies of brain. In: Surgical treatment of the nervous system. F. W. Bancroft and C. Pilcher, Ed. Philadelphia, J. B. Lippincott Co., 1946, XVII, 534 pp. (See pp. 239-246).
9. Dott, N. Quoted by Olivecrona and Riives.²
10. Bassett, R. C., Surgical Experience with arteriovenous anomalies of the brain. J. Neurosurg., 8:59-74, 1951.

Help For The Hearing Handicapped

GORDON D. HOOPLE, M. D.^{*}

It is indeed the exceptional extrovert whose life's glow is not dimmed by a hearing loss.

One who has such a handicap tends to become introspective, self-centered and suspicious. In the game of life, those who are thus afflicted are excluded out, not included in. A hearing loss can cripple an individual as much as, or even more than, a broken leg.

As you all know, there are two kinds of hearing loss. One is conductive; the other perceptive. Each of these two kinds of hearing loss can be reversible or irreversible. A reversible loss is one which may be corrected and some, if not all of the loss, restored. In an irreversible loss, the changes are such that no methods known to medical science can improve the hearing ability of the ear involved. A conduction loss is often reversible but not always so. A perceptive loss is seldom reversible. A conductive loss which is irreversible does not present the problems of an irreversible perceptive loss. A person with a conductive loss is easily fitted with a hearing aid, and such an individual is usually very happy with one.

All one needs to do in such instances is to get sound to the inner ear with enough intensity, and then the ear can hear. This the hearing aid can do. In other words, if the intensity is great enough to push its way through the block that is present, the undamaged inner ear can still do a remarkably good job. Perceptive hearing losses are more difficult to help for a fair number of those who have such losses cannot wear a hearing aid successfully simply because the damage to the nerve produces enough distortion of sound or speech that no matter how loudly they enter the ear, they cannot be understood fully. It is rather

interesting to note that when a perceptive loss is profound, it more often than not affects those in the extremes of life, i.e., the very young or the aged. These are the hearing losses which reach a maximum in old age and are due to the vicissitudes of life as they happen through the years to affect a very sensitive organ, the ear, and are found in the young who are brought into life with a congenital hearing loss.

Fifty years ago, the phrase "deaf and dumb" was in common usage. I can remember as a youngster hearing about several people who were supposed to be "deaf and dumb" and wondered, as did many others, about their mentality. Gradually, through the ensuing years, we have almost ceased to use this phrase. This is because, very slowly but surely, we have added educational techniques to the training of the child with a congenital hearing loss, who has normal intelligence, till we have advanced to the point where fewer and fewer of these unfortunates grow up without acquiring understandable speech. Without doubt, the story of Helen Keller has been an outstanding encouragement to the advancement of this educative process, but this is only one shining example of the diligent work on the part of scores of people who have refused to let this crippling condition handicap children so they cannot develop into normal personalities. There have been marvelous improvements in electrical equipment, particularly since the advent of the electronic age, which has helped in this program. The notable improvements in the quality and character of hearing aids is one stepping stone in this advancement. The invention and widespread usage of the audiometer has taught us that very few of the so-called congenitally deaf are really totally deaf. These children may have a profound hearing loss, it is true, but in the

^{*}Professor Emeritus of Otolaryngology, and Medical Director, Hearing and Speech Center, Syracuse University, Syracuse, New York.

very great majority, there are some remnants of hearing left, and it is educable. It is an interesting commentary on our times that it took a war to bring some of these techniques to their finest fruition. This was done in the hearing centers which were established by the Army and Navy. The service rendered the returning veterans was so successful that it has been almost universal experience that no community can do better than to model its efforts in behalf of the hearing handicapped after these centers. There have been modifications, of course, depending upon local conditions, but, in general, their pattern has been followed. This tribute to these military endeavors is in no way a slight on the work of the pioneers in this field who originated centers and had them in operation long before the onset of World War II. These earlier centers were not the equivalent of the later ones, but they rendered a real service to many.

One of the really significant advances since the war has been the origin and use of a method which tests hearing objectively rather than subjectively. Prior to the war, practically all methods for testing hearing depended upon the subjective response of the individual to the testing tone, i.e., one had to depend on the honesty and intelligence of the tested person for an accurate appraisal of the hearing loss. This meant that the responses of children under six or seven years of age were quite unreliable and often useless. About five years ago in Baltimore and since in many other centers, an objective method of testing hearing was put in use. This employs the principle of the conditioned reflex and the individual's reaction to it. The method is known as the psychogalvanic skin resistance test. Negative and positive electrodes are put on the front and back of the hand or the foot and connected with a galvanometer which shows response to any variation of electric impulses between the two electrodes. Sound is introduced into the ears of an individual undergoing this test, and the sound is followed in a few seconds by an electric shock. This sequence is repeated until the individual expects a shock everytime a sound is heard. With the expectancy of the shock, there is sweating of the skin which changes the electric potentials of the two electrodes, and

this can be measured as shown in the galvanometer. Thus, the hearing of a child can be tested with some degree of accuracy. I have seen this done successfully in a child seven months of age. This means of testing hearing may not be the final method of choice for the objective testing of hearing, but it has proved to be a boon to the programs of all hearing centers which have employed it. One cannot always obtain a satisfactory reading, but it is possible to do so most of the time. With its successful use, the amount of hearing loss can be determined very early in life and the whole educational program which is necessary to bring out the best in a child can be outlined to the parents at the time of testing.

In the Syracuse University Hearing Center, psychogalvanic skin resistance tests have been employed over four and a half years. A sufficient time has elapsed so that a comparison between the early tests and those done several years later by regular audiometry has been made in many instances. A remarkable correlation between the two has demonstrated the reliability of the so-called skin test. Further perfection of electroencephalography techniques give promise that this procedure may furnish another and even more reliable means of testing hearing objectively. This is another help for the hearing handicapped which is probably just around the corner.

In almost every instance, children with a congenital loss (even though it is severe) can be taught, and in turn, learn to speak themselves. Class work in special schools is necessary in most instances, but training at home is equally important. Either at home or school, there must be frequent repetition of words and phrases in conjunction with appropriate pictures and a chance given for the child to observe the associated movements of the muscles of the face and lips. Amplification of sound is added, first with the use of a table model hearing aid or a group hearing aid, and later with the use of the child's own individual aid. Such children can go on to a college education and make their way successfully in after-life. I have seen and personally know several who have done so, amongst them one who acquired a Phi Beta Kappa key en route.

The training of adults with a severe hearing

loss differs from the training of children only in the advanced lesson material which the adults can assimilate. I know of one woman in her forties who had suffered a severe hearing loss in early childhood. She had never had any auditory training and she had never worn a hearing aid. Two years ago, she took a course of auditory training. I saw her after several weeks of such exercises and the afternoon I watched her, she correctly interpreted, without the aid of lip reading, better than fifty per cent of the material which was put into her ear. She admitted to me there that previous to this training, she had not understood anything that had been said to her for forty-three years.

A few weeks ago, I saw in my office, a young girl of twenty-two who came to me for an appraisal of her hearing. She was a senior in college and was seeking advice about future employment, marriage, etc. Due to an attack of meningitis, she had lost much of her hearing when she was ten years of age. She had worn a hearing aid in one ear for the ensuing twelve years. The hearing loss for pure tones was almost equal in the two ears. However, in the ear in which she had worn the hearing aid, she had the ability to hear correctly 92% of test words which were given her. In the opposite ear, which she had not used at all for hearing for twelve years and where there had been no such training in the interpretation of sounds, her ability to understand spoken words was only 20%. This was one of the most dramatic instances of the value of auditory training that I have ever encountered.

The aged can be helped by these techniques without any question, but unless older persons have active minds and are eager to learn, it is more difficult to teach these than it is the young. To some extent, they must learn to help themselves. I am convinced that there is a process which goes on in the aged which Dr. Raymond Carhart calls phonemic regression. This is a gradual loss of the ability of the mind to interpret distorted sound. Unless the mind of the aged person is kept "alive", this process can be handicapping indeed.

I have mentioned the use of lip reading, which is now called speech reading. It has been shown statistically that one who can speech read can use a hearing aid 30% more

efficiently than one who cannot. This is a vast difference. Think of missing one-third of the things that you are supposed to hear, and you can appreciate what speech reading can mean to a hearing handicapped individual. No person who has such a handicap should be without this exceedingly useful help.

In most of the foregoing, I have been speaking about aid for irreversible hearing loss. It is hardly necessary to add that where medical or surgical measures can be employed to restore part or all of a hearing loss, they should be instituted. It is little short of criminal not to do so. One of the outstanding advances of the last two decades is the perfection of the fenestration operation to the point where, in the majority of instances in suitable patients, hearing can be restored to a practical serviceable level. This has been a boon to many individuals. Adenoidectomies are done more carefully than formerly. Sinusitis is managed more efficiently. In all, we have reduced immeasurably the crippling effects of hearing loss during the past decade. I know of no field in medicine where the advances are as dramatic and promising as they are in the field of audiology, the science of hearing. Research is going on all over the country, and it is difficult to predict all of the benefits that may come from it.

I have talked thus far about some of the help that is available for those who have an irreversible loss. What I think is more exciting and more interesting is the possible prevention of these hearing losses. Among several causes, there are six which come to my mind at the moment which have crippled many in the past and which may be on their way out. Some of them actually are. The first of these are the conditions which cause a child to be born with a congenital hearing loss. There probably always will be the sporadic case of hearing loss in a new-born child despite all the preventative measures we institute. And we do not know the cause in each instance now, but we are gradually learning some of them. We now know that the severe jaundice which sometimes follows an Rh factor incompatibility in pregnancy may cause a severe hearing loss. We also know that a baby who is a so-called blue baby in the first week or so of life may

suffer a hearing loss because not enough oxygen is in the blood in these first few days to give adequate nourishment to the ears so they can live to the full. The result is that part of the ear dies and never functions again. We know too that rubella (German measles) suffered by a mother in the first trimester of her pregnancy may result in the birth of a child with a severe hearing handicap. This child may also have congenital cataracts and heart disease. Here are three conditions which we know can cause a congenital hearing loss. There is hope that the appropriate management of an Rh incompatibility with a subsequent markedly jaundiced baby may prevent a possible hearing loss. The proper administration of oxygen or the employment of other necessary remedial measures to a blue baby may prevent damage to hearing.

Should a young woman who has had rubella and who is in her first three months' of pregnancy have an abortion? This question has been raised. There are arguments which say no, particularly religious ones. But an enlightened society is beginning to question them. There is growing evidence that some day it may insist that the answer be changed to yes. This brings philosophy and religion into the picture, and there appear to be stone walls which cannot be assailed, yet we should all remember that thinking over the years changes and there is nothing in this world as certain as change. Our thinking in this regard may be different some years from now. There are some preventive measures which were not in existence a mere ten years ago. Here's hope that there will be fewer congenitally deaf babies in the future.

The second of the six causes which I suggest may be on the wane are the hearing losses due to infection. Fifteen years ago, in New York State, ten per cent of the children in the elementary schools had a significant hearing loss. Today, in many New York State communities, this figure has been reduced to two or three per cent. While all its communities do not have as favorable a showing, the overall state percentage is less than five per cent. I am convinced that this figure can and will be reduced even further. This great advance is due in large measure to the advent of the

so-called wonder drugs, the sulfas and penicillin. I do not know the percentage improvement for the rest of the country, but I am sure other states can show a similar change. This is a notable advance.

A third condition which is receiving recognition not given it five years ago is the frequent occurrence of secretory otitis media or otitis media with effusion. This condition frequently follows infection and is often a remaining factor in the ear after the use of the antibiotics. The continuing presence of fluid in the ear may or may not result in changes which will produce an irreversible loss. As long as fluid alone is present in the ear, the condition is still reversible. However, uncorrected continuance of etiological factors can cause changes which will be irreversible. Five years ago, this condition was the most frequently missed of all otological diagnoses. It occurs more often in children than in adults. Consequently, its threat to hearing is more important than some other conditions. Fortunately, pediatricians are becoming aware of it and diagnosing it with increasing frequency. Proper treatment, in almost every instance, can eliminate the presence of fluid and its possible damage to hearing. Secretory ears will continue to plague us, but prompt recognition and appropriate therapy will largely eliminate irreversible hearing losses due to this cause.

A frequent cause of hearing loss in later life is that which is due to the fact that the ear does not have its proper blood supply, i.e., the loss that follows arteriosclerosis or atherosclerosis. Some very exciting research is underway, the final conclusions of which are not yet available, which show that it may well be that proper medication will prevent this loss, which is also an irreversible one.

To prevent this type of loss, a physician must be aware of the fact that the individual has poor vascular supply to the ear, and a hearing loss may be present sometime in the future or an additional loss will occur if remedial measures are not instituted. This is preventive medicine of the highest order. That all hearing loss due to this cause may be prevented is not yet a prediction. Research only gives promise that it may be, but this is certainly exciting. It is particularly exciting because very often in

this type of hearing loss a hearing aid has no value.

A fifth cause of hearing loss which may diminish is that which is due to allergy. Allergic sensitivity sometimes includes the ear. Occasionally, this causes a sudden severe loss. More frequently, however, as a result of repeated minimal allergic episodes throughout life, in later years there is a fair degree of the loss of hearing due to a gradual degeneration of the nerve of hearing. Many children, as well as adults, today are under allergic management and because of this, I predict in the future, we will see much less of this type of hearing loss than we see today. For some of the adults, the allergic management has been instituted too late to prevent a loss. The great hope is with the children.

Finally, and sixth, I think of the loss of hearing that is due to exposure to industrial noise. To injure hearing, industrial noise must be very loud, and ears must be exposed to it over a period of years. It is found frequently in many workers in the heavy industries. Fortunately, the ears of all workers are not equally sensitive. Some are resistant to noise exposure, but the number of men who are riveters, chippers, drop forge hammer workers, etc., who have a respectable hearing loss due to exposure to the noise of their occupation totals more than one likes to think. This has been recognized as a threat to hearing for more than one hundred years. Fosbrooke, as long ago as 1831, wrote about this kind of hearing loss, but unfortunately, very little was done about its prevention until recently. Industry was unwilling to take steps to correct this situation because there had been no claims for compensation for industrial hearing loss. Apparently, management felt that to institute corrective measures would awaken labor to the fact that his was a

compensable condition. Management evidently feared a flood of claims. Their fears were correct because the flood of claims has begun. Awakened by the activities of the Committee on Noise in Industry of the American Academy of Ophthalmology and Otolaryngology, industrial management, union leaders and insurance officials are now very cognizant of this industrial hazard. Preventive measures in the form of reduction of noise at its source and the prevention of damage to the ears, if the noise is not reducible to a safe limit, by the wearing of ear defenders are fast becoming the order of the day. Some really significant changes in the picture are just around the corner.

If these six causes of hearing loss are even partly eliminated, the amount of human suffering that can be eliminated is incalculable. There is promise that this may be so in each one of these instances.

In relating to you the techniques which are now available for use in helping handicapped and which our forebears did not have and the very exciting news that some hearing losses may never occur at all, I do not mean to say that the problem of handicapping hearing losses will disappear. We will undoubtedly have a good deal of it with which we must cope for the rest of our lives, but just as today we look askance at one who condemns a young child to a life of limited usefulness by saying, "It is deaf and dumb" and refuses to do anything about it, some of our descendants will probably look back on this day and wonder why we had so much hearing loss, why we managed it so poorly and why we allowed it to become such a handicap. It is thrilling to take these peeks into the future. Because of them we should double our efforts. There is every promise if we do just that there will be much less suffering amongst us. There is help indeed for the hearing handicapped!

The legislative program, as it relates to health, health insurance, and Social Security, is beginning to shape up. The Republicans have learned from Democrat experience that American medicine cannot be nationalized at one fell swoop. The proper technique (politically speaking) is to creep up on the profession by inches. No politician of either party would want to alarm the medical profession unduly.

Therefore, as the Democrats learned when they abandoned the omnibus Wagner-Murray-Dingell-bill type of legislation, the thing to do is to take over physicians piecemeal. A program here, a program there does not alarm most physicians, especially since they are singularly obtuse when it comes to protecting their professional freedom.

"Challenge to Socialism"

Medical Botany in South Carolina Two Centuries Ago

J. HAMPTON HOCH,

School of Pharmacy, Medical College of S. C.

Ever since the early days of exploration and colonization of our state both laymen and physicians have been interested in native plants which might become useful additions to the materia medica. Prior to the middle of the eighteenth century the only significant contribution to the botany of South Carolina was Mark Catesby's investigation of our flora during the years 1722-1725. The "Natural History of Carolina, Florida and Bahama Islands," published in London (1731-1748), contained his observations on South Carolina plants.

Dr. Alexander Garden, who emigrated from Scotland in 1752, became actively interested in botany immediately after his arrival in this Province. It was his "eager desire to learn something of the Nature of the herbs and their Names which the Ethiopians and Africans use for poison and the common method of cure." He says the negro slaves had a considerable knowledge of vegetable poisons which they used "to take away the Lives of their Masters, who they think uses them ill, or indeed the life of any person, for whom they Conceive any hatred or by whom they imagine themselves injured."

This unhappy situation had led to the passage of a law (May 17, 1751) "to prevent all slaves from attaining the knowledge of any mineral or vegetable poison," making it unlawful "for any physician, apothecary or druggist to employ any slave in the shops or places where they keep their medicines or drugs." But poisonings and the fear of poisoning seems not to have abated for some years.

A negro slave named Caesar had devised a "Cure for Poison and . . . for the bite of a Rattle-Snake." The Commons House of Assembly purchased his freedom and granted him an allowance of 100 pounds a year for

life for his secret remedy. This "cure", which then was published in the newspaper,* used decoctions of plantain, wild horehound and goldenrod roots. Dr. Garden was distressed that "the Gentleman** who was entrusted with the Publication (tho a practitioner of Physick) has neglected to give the Least Characteristick of any of the Plants whereby one should know them . . . What he calls the Marrubium Sylvestre is entirely different from the wild horehound in Europe . . . I've already seen four kinds of the Golden Rod here . . . I imagine they are all taken indiscriminately." This lack of adequate botanical identification of the plants employed is not surprising if we accept Garden's opinion his colleagues: "I find most of the Practitioners here so totally ignorant of Botany, that if it was not from what they learn from the Negroe's Strollers and Old Women, I doubt much if they would know a Common Dock from a Cabbage Stock."

Caesar did not enjoy his annuity very long since the will of "Doctor Ceser . . . Practitioner of Physick" was recorded in 1754.† None of the three plants which comprised his antidote became important drugs. However, domestic lay use of the roots of the common large plantain (*Plantago major* L.) in intermittents, of wild horehound (*Eupatorium rotundifolium* L.) as a "tonic febrifuge," and of goldenrod (*Solidago* species) for wounds and snake bites is recorded many decades later.

The outstanding contribution of South Carolina to the materia medica at this period was the vermifuge, pink root (*Spigelia marilandica* L.). The use of this drug was learned from the Indians and Drs. Moultrie, Garden

*South Carolina Gazette, Number 835, May 7 to May 14, 1750.

**James Irving (1713-1775), also a Scotch physician who had come to Charleston about 1745.

†His wife and daughter were at this time still slaves of Capt. Norman.

*Letter of Jan. 21, 1753 to Dr. Alston, Professor of Physic and Botany in the University of Edinburgh.

and Lining had sent samples of it back to the Edinburgh faculty. Alexander Garden's name is most intimately associated with the "Lonicera . . . Indian Pink root." His "Description, History and Account of our Pink root" was sent to Dr. Whytt of Edinburgh in 1756. A Century

later it remained the most widely prescribed anthelmintic in the U. S. The recommendations of the Charleston physicians, Garden, Lining and Chalmers, had securely established its reputation.

The major portion of scientific opinion is that fluoridation of water supplies for the prevention of dental caries presents no hazard to public health. A minority view is held by a number of qualified scientists who believe that the safety of this procedure has not been sufficiently demonstrated. Cognizant of the fact that fluoride compounds in large doses are poisonous, they advance the hypothesis that the small amounts contained in fluoridated water consumed over many years may by cumulation have subtle physiological effects especially detrimental to the aged and the chronically ill

. . . . The Commission has been advised by the foregoing expert opinion that extensive research into the toxicology of fluorine compounds has revealed no definite evidence that the continued consumption of drinking water containing fluorides at a level of about 1 p.p.m. is in any way harmful to the health of adults or those suffering from chronic illness of any kind. While the evidence does not absolutely exclude this possibility, if a risk exists at all it is so minimal and inconspicuous that it has not been revealed in many years of investigation. The Commission, therefore, urges American communities to adopt this public health measure as a positive step in the prevention of the chronic disease, dental caries.

Commission on Chronic Illness

Misuse of Antibiotics. From a report on the Washington Symposium on Antibiotics, the *British Medical Journal* states, in part.

There seemed to be universal agreement that antibiotics were being grossly misused. Perrin H. Long (New York) picturesquely described the American populace as "an enormous sponge with an infinite capacity for absorbing antibiotics." Maxwell Finland (Boston) referred disapprovingly to the common practice of administering many drugs successively or together for no more precise indication than fever, and blamed advertising

pressure for some of this. Sidney Ross (Washington) described the profession as being "inundated literally with a plethora of drugs," and made a plea for a return, for many purposes, to an earlier, simpler, cheaper, and often no less effective treatment; he asked his hearers not to "write off an obituary of sulphadiazine drugs in the current high-power antibiotic era."

A great deal of such need as there is for new antibiotics is due to the waning power of their predecessors, which is a result of the acquired resistance of bacteria to them. . . .

New York State J. Med.

MEDICAL PROGRESS MOVES BACKWARD IN CHINA

Despite claims of health progress, the Chinese communist government is actually going backward as far as medicine is concerned, according to an article by Leslie G. Kilborn, former dean of the College of Medical Sciences in the West China Union University. The article appears in the April issue of *THE JOURNAL OF MEDICAL EDUCATION*.

The backward action is evident in the "rejection of the traditional system of ethics, the repudiation of the scientific spirit and the substitution of authoritarianism and the enforced lowering of medical education standards."

The communists have made it clear to doctors and medical students that in the new China all individuals are not equal under the law, and while all Chinese are citizens, only some qualify as "people." Others are classified as reactionaries, landlords or other types of "enemies of the people." These "enemies" are not entitled to the same treatment as "people" and the doctors are therefore compelled to diagnose not only the disease but the status of the patient. This, as Dr. Kilborn points out, repudiates every tradition of medical ethics, and makes the medical profession an instrument of enforcement of official policy.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring -----			82 Rutledge Ave., Charleston, S. C. ·		
EDITORIAL BOARD					
J. P. Cain -----	Mullins	Vince Moseley -----	Charleston	G. D. Johnson -----	Spartanburg
J. D. Guess -----	Greenville	Ben Miller -----	Columbia	R. M. Pollitzer -----	Greenville
C. J. Milling -----	Columbia	W. H. Prioleau -----	Charleston	Hugh Smith -----	Greenville
H. R. Pratt-Thomas -----	Charleston			Walter Mead -----	Florence
BUSINESS MANAGER: Mrs. C. G. Watson -----			105 W. Cheves St., Florence, S. C.		

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) -----	Charleston, S. C.
Subscription Price -----	\$3.00 a Year

MAY, 1954

Wiggly Higley

We wonder whether our readers know much about the vehemence with which the American Legion and the Veteran's Administration are attacking the medical profession's stand on the question of hospitalization of veterans. Our eyes were opened a bit after reading a copy or two of Army Times *Vet-Letter*. These are samples of the approach.

"VA Administrator Harvey (Doc) Higley . . . in extemporaneous talk before big throng attending opening session of Legion's 31st annual rehabilitation conference . . . did neat bit of diagnostic probing into motives of *American Medical Association* in their attacks on VA free hospitalization program . . . decided all symptoms of socialized medicine were present.

"VA chief . . . who is son of doctor and father of doctor . . . used best bedside manner in talks before Legion groups . . . showed own skill with verbal knife in performing major operation on AMA . . . cracked that upper income bracket doctors probably pay plenty of taxes—on the income they report . . . after full minute of Legion applause confessed remark was little below the belt . . . charged AMA accusation that VA pays doctors too much certainly isn't true . . . paradoxically said as long as we can make 'em stick to the truth, I hesitate to go on warpath.

"But sweet-talking Higley was on warpath . . . said AMA doctors have no program . . . are criticizing VA without offering substitute plan . . . that ultimate aim of AMA is to take over all VA hospitals and put them under State and county control . . . that ultimate result will be socialized medicine . . . asked where VA would get \$555 million required to operate VA hospitals for veterans . . . said AMA would be run-

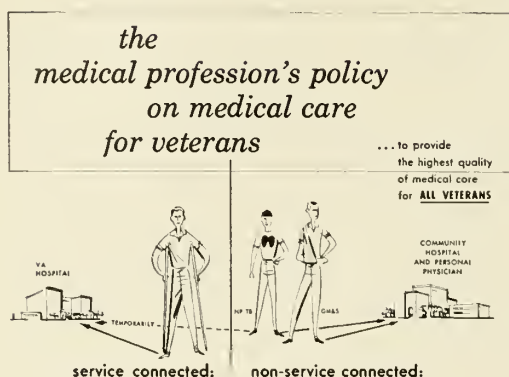
ning hospitals for all citizens and would have to go to Federal government . . . asked whadaya got? . . . got shouted Legion prediction of socialized medicine.

In another issue we read:
"THE GREAT UNMORAL: Ultimate goal of butchers' wing of American Medical Association . . . in current and scheduled attacks on Veterans Administration hospital policies . . . not simply to limit VA medical care to those unable to pay for treatment of non-service-connected ailments . . . but to get Congress to deny hospitalization to *all* veterans who cannot *prove* disabilities were incurred or aggravated by military service.

"AMA's Orr piously asserts that it is morally wrong to have 2 classes of citizens: *veterans* entitled to free hospital and medical care if they are unable to pay for private hospitalization, and *nonveterans* who must pay for their own; doesn't say it is morally wrong to force one man to fight for his country while another stays home to profit through war boom; declares it is both morally and economically wrong for nonveterans to pay own medical expenses and also be forced to pay taxes to support veterans' medical programs; doesn't say it is morally wrong or economically wrong for veterans to be taken from jobs, businesses, homes, schools, etc., to wage war while non-veterans' lives remain relatively undisturbed.

"Meanwhile . . . in determined drive to inoculate public with *anti-veteran* poison . . . AMA has scheduled additional regional conferences to lambast VA medical care.

"Despite immoral and unmoral attitude of AMA leadership . . . V-L remains unconvinced that majority of nation's doctors and physicians would support House of Delegates in free-vote



The medical profession stands for the highest quality medical care for all citizens. Veterans, as citizens, should accept the responsibility for their own health needs—unless they become disabled as a result of military service; then it is the responsibility of the Veterans Administration to provide medical care and hospitalization. Because many communities do not as yet have adequate facilities to care for war veterans with non-service-connected tuberculosis or neuropsychiatric disorders, the medical profession recommends that the VA continue—on a temporary basis—to treat these patients.

*effects of
present veterans medical legislation*



It is the belief of the medical profession that it is unsound to authorize free lifetime medical care for veterans who suffered no mishap in uniform, while other citizens with no military background must pay their own way. Although the two men above are identical, they represent "two classes of citizens"—the veteran with no service-connected disability who is granted medical care at federal expense, and the non-veteran who must personally assume responsibility for his medical care.

showdown."

Comment seems superfluous.

The Laboratory Fee

Not long ago a conversation was heard in which the complainant deplored that it was too bad that his hospital patients had to pay so much for laboratory fees that there was little left for payment for the doctor's services. He went on further to say that his patients sometimes complained of the fees and that he was inclined to sympathize with them and cast aspersions on the laboratory or the hospital for the excessive charges.

There was a temptation to ask this doctor whether he himself had considered the cost of the procedures used and whether he had explained to the patients that they were necessary and, incidentally, expensive. Certainly the laboratory is an essential part of a hospital, and the medical laborer in the laboratory is truly worthy of his hire.

One is inclined to think that there are many doctors who call for quantities of laboratory

tests which are not always of clinical value, and that sometimes an oversight in failing to cancel a standing order may run up an unnecessary clutter of reports. The average hospital cannot provide unlimited laboratory facilities without recovering costs from patients, and the average patient probably needs much less than is done for him by the laboratory.

The difficulty does not lie in either hospital or patient. One might misquote—"the fault, dear Brutus, is not in our hospitals, but in ourselves."

Varicose Veins

The Case Against Injection Therapy

The treatment of varicose veins by the injection of sclerosing solutions, whether used alone or in conjunction with operation, continues to enjoy popularity because of its ease of execution and generally good early results; also on account of its patient appeal based upon avoiding or reducing operative procedures and accompanying hospitalization. In

spite of this, it can be categorically stated that this method of treatment should be discontinued as its use is based upon the false premise that the extent of the induced thrombosis can be controlled and that the deeper veins are immune to the irritant action of the sclerosing solution.

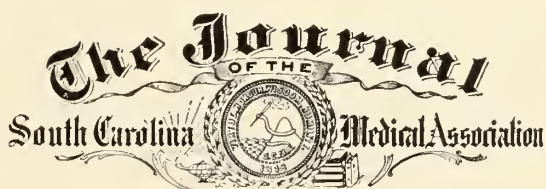
The definitive treatment of primary varicose veins is directed toward relieving the resultant venostasis with its sequelae of dermatitis, ulcer and phlebitis. This is accomplished by reducing the size of the pathologically enlarged superficial venous bed and protecting the superficial venous system from reflux flow and increased pressure from the deep venous system transmitted through communications with the saphenous systems and other perforating veins.

As varicosity of the veins is a progressive degenerative disease affecting more or less generally the walls and valves of the superficial veins of the involved lower extremity, treatment to be effective consists of obliteration of the subfascial trunks and larger tributaries and plexuses of the saphenous systems, and incompetent perforating veins of other than saphenous origin. By the injection of sclerosing solutions the size of the superficial venous bed can be effectively reduced; however the thrombotic process cannot be controlled so that it extends in the communicating veins just to the level of the deep fascia or the junction with the deep vein. Failure in this respect commonly leaves channels through which the pressure from the deep veins continues to be transmitted to the superficial system, causing recurrence of the varicosities. There is also the danger of the thrombus extending into the deep vein and giving off emboli. Large thrombi in dilated veins or plexuses often require evacuation by incision. Where extensive injection is used at the time of operation a fulminating thrombophlebitis with accompanying arteriospasm may endanger limb or life. Technical methods intended to control the distribution of the injected fluid cannot be depended upon, judging by the venous pattern seen in venograms and at operation. This is particularly the case in varicosities connected with incompetent perforating veins. The entrance of the sclerosing

solution into the deep veins may cause thrombosis with resultant permanent damage. Damage to valves may occur in the absence of thrombus formation. Such damage to the deep veins manifests itself slowly by the development of venostasis as in the post-phlebotic syndrome. Of lesser importance recanalization may take place in veins once completely occluded by thrombosis. Recurrences following injection therapy are generally refractory to treatment.

The treatment of varicose veins by the injection of sclerosing solutions should not be used, particularly because it is attended by too great risk of permanent damage to the deep veins. The method of choice is vein excision and ligation at open operation under visual and palpable control. This is productive of the best results and is practically devoid of the complications accompanying injection therapy.

—William H. Prioleau



Forty Years Ago

MAY 1914

Dr. Edward F. Parker had been elected President.

The Sims Memorial was still under discussion.

A paper on pellagra describes it as a "specific infectious disease." Arsenic was recommended as a valuable drug in treatment.

Omnia in Risu

IT'S ALL IN FUN

I can remember very well one of my encounters with our former Dean, Dr. Robert Wilson and after a very lengthy, hurried and disjointed explanation of my particular problem, Dr. Wilson stopped me with this, "Son, Why don't you stop a minute and say WHAT YOU MEAN." My friends, I stopped. I still can't recall how I finally finished up with this particular conversation but I am certain of one

thing; the Dean wasn't running second. This conversation "LEARNED" me though. I have thought many times since then—Boy, why don't you say what you mean—And as a matter of fact since I'm writing this to YOU, Why don't you say what you mean—or do you?

Of course situations may determine to a certain extent just what we do mean. Now, let's take ole Rastus who is 'phoning Mandy. "Mandy, I've got a good farm, two mules, three cows, some pigs and a nice little house; will you marry me?" Mandy answers right back; "Honey Chile, I sho will—WHO is dis talking?" Here is an instance in which Rastus said what he meant and Mandy was really hoping he meant what he said.

It is recorded somewhere that there are those who mean what they say until they run into a rather commonplace complication. For instance I knew a young freind who before he married said, "When I'm married, I'll know who is Boss in my house." Well he married and now he knows—same as in your and mine—the wife. I know for certain however that circumstances change the entire picture and one can afford to be a bit more positive at times. There is the story of the wife of the creditor-harrassed business man who told her husband that she *must* have a new car. "I have my heart set on that green Cadillac convertible." "Well," her husband yelled, "unless business conditions change quickly for the better, your heart will be the only part of your anatomy that will set on it."

Then there is the instance in which *we* will not *understand* that which we have heard. This is the story of the rather dignified (pompous) man whose car became mired in the terrible dirt roads near the proverbial farm house. Realizing that he must spend the night somewhere nearby he inquired of the old farmer for lodging. The farmer said he would be glad to accommodate him but added "you'll have to sleep with the teacher." "Sir," the motorist replied, drawing himself up in all his dignity "I'll have you know, I'm a gentleman." "Well," the farmer drawled, "that's alright SO IS THE TEACHER!"

After reading the two very fine articles by Drs. Prioleau and Johnson I believe that the physicians have an opportunity to really say what they mean about Health Insurance—the Voluntary way. It seems to me that actions actually speak better than words. There is no place in medicine now—if the proposed voluntary health plans work—for the dishonest *patient*, *physician* or *insurance worker*. It will require the concerted effort of all three of these equally important factors if we are to carry on medicine in true democratic fashion. This is one time when we can say what WE

MEAN AND MEAN IT.

BLUE SHIELD — BLUE CROSS

The new "Manual and Schedule of Physicians' Allowances" has been published and has been distributed to Blue Shield's Participating Physicians. In many respects, it is one of the most complete statements of principles used in the making and processing of physicians' reports of services rendered subscribers and of allowances made for those services in use by any of the affiliated Blue Shield Plans. It is urged that both Participating Physicians and their secretaries read the manual carefully and then use it for frequent reference. By doing so, many of the oversights and omissions which have been so frequent in the reports up until now will be eliminated. Understanding derived from a study of the manual and a little care in preparing the reports will eliminate delays, lessen correspondence and reduce overhead expense. Perhaps, most of all, they will prevent annoyance and resentment which requests for additional information sometimes cause.

All code numbers have been changed to correspond with the system of coding set up by The National Association of Blue Shield Plans. There have been incorporated many cross references, making it easier to find the proper listing for procedures which might have been listed in some other section than that in which they actually occur. Proper coding aids in describing the operation or other service rendered. Such coding is not difficult to learn.

An effort has been made to explain the way in which fee allowances are determined in multiple procedures when done by a single surgeon or by more than one surgeon. When more than one doctor has attended a subscriber, each doctor should make his own report, stating what he personally did—but he should also make reference to colleagues who were associated with him. Then no report will be processed until reports from each of the doctors are in. It is suggested that reports not be made until the case is terminated and that the reports give the final diagnosis rather than the presumptive or admission diagnosis.

The new schedule of fee allowances is overall much more liberal than that which it replaces. Although our limit for any one surgical procedure or operation remains at \$150.00, our *per case* limit goes as high as \$350.00. Thus, compensation for cases involving multiple procedures or repetitious operations becomes more realistic, and in practice sometimes exceeds fees of plans which have a \$200.00 or higher limit.

All coded operations have not been printed in the schedule. Some rarer procedures have been omitted to keep the manual from being too bulky. Those omitted are on file in the claims department, and appropriate code numbers will be inserted in the reports as they come in.

The Medical Director was sick when the proof was ready for reading. The Executive Director did an excellent job of proof reading. However, there were

some errors in the printer's copy and some omissions which he could not recognize. These have been corrected in master copies in the claims department, and the corrected figures will be used in processing the reports. At some future time, a supplementary sheet carrying these corrections will be printed and distributed.

No manual of procedure, and more particularly no fee schedule, is static. Errors are discovered and corrected from time to time. Fees which are unfair or out of balance with the rest of the schedule are adjusted. Actuarial experience sometimes demands changes. The Board of Directors asks that every Participating Physician consider himself a member of the advisory committee on fee allowances, and it will give serious consideration to any suggestions which may be made.

Anesthetic allowances have been increased to a maximum of \$20.00. These are covered, however, by the Medical-Surgical Agreements only. There are still in effect a good many memberships under the original Obstetrical-Surgical Agreement which provides no medical and no anesthesia protection.

Medical benefits have been considerably improved. These will be of value to both the Participating Physician and the Subscriber. These are fully described in the manual.

Blue Shield, The South Carolina Medical Care Plan, the doctors' plan, operated by the South Carolina Medical Association in an effort to provide good medical care to the people of the state, at a price they can afford to pay, offers a mutual, group, non-profit, prepaid type of insurance against the hazards of accident and illness. For the persons of moderate means it affords service benefits in surgical cases and obstetrical delivery. For all members, it affords cash indemnity to apply on the medical bills in cases of hospitalized illness.

PUBLIC HEALTH

The following discussion of a paper on "The Changing Problems in Public Health" by Dr. Wilson T. Sowder was given by Dr. Ben F. Wyman at the November, 1952 meeting of the Southern Medical Association and is reprinted by permission of the Southern Medical Journal.

Discussion by Ben F. Wyman, M. D. on
**THE CHANGING PROBLEMS IN
PUBLIC HEALTH**

By Wilson T. Sowder, M. D.
Sou. Med. Jour.—46-589—June 1953

... Prior to 1878, there was no state public health program in South Carolina. There were, however, certain public health laws. Most of these laws were directed toward quarantine against the introduction and spread of yellow fever. Since yellow fever came in by boat and since, when epidemic, it affected the coastal area, Charleston was its principal center. The first law with that objective was passed in 1698. In 1712, what might be considered the first state health

officer was created by law. His duties were to examine ships' passengers at the entrance to Charleston harbor and to determine whether or not it was safe for the ship to dock.

In 1875, the South Carolina Medical Association appointed a committee called "Committee on State Medicine and Public Hygiene." The report of this committee states "There is no more correct and certain index of the successful working of a government conducted only in the interest of the people than the laws which exist and are enforced for the preservation of health and the warding off of disease."

As a result of the continued interest of the medical profession and finally of the Legislature, in 1878 there was a law passed providing for the State Board of Health. Then as now, it provides the South Carolina Medical Association, the Comptroller General and the Attorney General, in their official capacity, to be a Board of Health. Provision has been made for the Executive Committee of seven doctors, one nurse, one pharmacist, and one dentist together with the two constitutional officers named, to function during intervals between meetings of the Board of Health. As far as we know, the Board of Health is never called together and the Executive Committee carries on its duties and functions.

The original law assigned several important duties to the State Board of Health. Perhaps, the most important was that of investigating the causes, character and means of preventing such epidemic and endemic diseases as the State was liable to suffer from by reason of climate, location, occupation, water supply, drainage, street cleaning practices and other similar factors. It should be noted that each of the factors named were widespread in action, affecting large groups of people equally. There was no intention to assign to the Board of Health any role in the treatment of the individual.

To show the interest and desire of the medical profession, because truly the Board of Health of South Carolina is the medical profession, the Second Annual Report of the Board to the General Assembly elaborates on this extensive program. I wish to quote a statement from the report as follows: "The following are subjects for consideration and special reports as time and means permit:

1. Best modes of securing and preserving the health of the body from a knowledge of its vital process, etc.
2. Vital statistics.
3. General sanitation.
4. Prevention of diseases.
5. Cost of epidemics: Economy of sanitation.
6. Nature and danger of contagion, putridity, etc.
7. Forcible isolation of infectious cases.
8. Construction of hospitals and infirmaries for communicable diseases.
9. Longevity in the different counties.
10. Geographical, geological, climatic and other factors in health and longevity in the several counties.

11. Meteorology and its effects upon health.
12. Botanical, mineral, agricultural and other resources of the State, and their effect upon health and longevity.
13. Influence of moisture, or its absence upon the production of consumption.
14. Personal hygiene and its effect upon production and prevention of disease.
15. Air purification and ventilation in homes and places of assembly or congregation.
16. Water pollution and purification.
17. Construction, management and disinfection of water closets, privies, etc.
18. Model lodging houses—cheap homes for the poor.
19. Accident prevention and treatment.
20. Cremation and burials.
21. Study of high death rate in Charleston and its effects upon trade and prosperity.
22. Various trades in villages, towns and cities.
23. Instruction in sanitary science, hygiene, etc.
24. Topographical, sanitary or other features of towns and cities and sections, with a study of their advantages or defects.
25. The nature and treatment of inebriety and legal management of inebriates.
26. Prevalence and prevention of criminal abortion."

It is unlikely that this ambitious program was ever completed. However, I think that it should be stressed that each of these twenty-six projects was within the field of public health. They had a bearing on mass or territorial prevention of disease. In no way did they attempt to invade the province of the private practice of medicine, and in no way did they seek to come between the private practitioner and his patients. . . .

. . . . The public health programs, after years of achievement, have drifted rather far afield from the objectives expressed in the Second Annual Report which was herein reported. Our activities have moved well over to a borderline area between public health, or preventive medicine, applied to the group, and that of the individual treatment of cases of disease. Many of these programs have primarily come about as a result of funds from the Federal Government. At the present time, more than half of the moneys expended by the Health Department has come from Federal grants and appropriations. As a result of the expansion of activities made possible by these grants, either because such funds helped finance particular projects or because they liberated State moneys for other purposes, the treatment of individuals has been undertaken. Some of this treatment is remotely preventive as applied to the population as a whole. In our State an example would be the State Hospital for the treatment of tuberculosis. The therapeutic features of the Venereal Disease Control Program is another. However, the Crippled Children Program and the Rheumatic Heart Disease Program are directly curative without any element of prevention.

One of the problems connected with the future is the extension of activities to therapeutic medicine in

the interest of the individual and, of course, this has and will bring about the greatest criticism. If this type of activity was limited to the true indigent, if it was charity state medicine, there would be less criticism. However, the problem of indigency, as handled by certain welfare groups, is the cause of great concern for there certainly is great laxity in the interpretation of the word "indigency".

We, in South Carolina, believe that we are trying to stay away from the problem of the Federal Government leading us into the welfare state or socialism and the insistent and incessant efforts of the administration to inaugurate a system of State medicine.

From the foregoing, it is very evident that whatever type of program is undertaken in South Carolina it must meet the approval of the medical profession because, truly, the medical profession is a State Board of Health for this particular State.

We have noticed, with many misgivings, the many statements and efforts that are being made and, in part, being carried out to provide replacements for the medical administrator.

. . . . We have, in South Carolina, considerable difficulty in securing medical directors. It is an impossible situation. We have tried to supply proper medical supervision by grouping two or three counties in so-called districts under the supervision of a doctor. This has not worked as his time is so taken up with going from place to place, directing three health units and doing emergency work that there is little time for any constructive or administrative activities. It has occurred to us that the doctor should be given the opportunity to carry out more clinic work. We believe this would interest the doctors and would probably allow us to secure physicians that are not now available. Most doctors should really do little administrative work for they want to examine patients and be in the field of medicine. If it was possible to have a type of program wherein lay assistants could administer certain phases of the same, the doctor's time and attention could be devoted to the many medical problems.

The problem of a lay administrator charting a course or establishing policies should not be undertaken. He should merely be an assistant, call him what you may, to the medical director. I do not think the terms of health officer, assistant health officer or lay health officer are at all advisable. He is an assistant to the medical officer to carry out the policies and programs that have previously been approved and mapped out by such medical officer. . . .

BOOK REVIEWS

MY HEALTH RECORD—William C. Cantey, M. D.—The Health Record Co., 1805 Glenwood Road, Columbia, S. C. Price \$2.00.

This is a handy and durable pocket-size booklet of 44 pages which provides space and headings for all the information necessary for an up-to-date picture of an individual's health. There are sections for immunizations, idiosyncrasies, diseases, and health matters, which bear on the past and present state of

medical affairs.

Information from such a record should be invaluable to the physician and to the patient, especially when the latter is travelling. If a record of this sort could be shown by the patient to his physician, much questioning and uncertainty could be avoided, and more accurate data could be used.

J. I. W.

CURRENT THERAPY 1954—Edited by Howard F. Conn, M. D.—W. B. Saunders Co. Phila. and London—Price \$11.00.

This is the sixth of an annual series, designed to present succinctly the latest word by many authorities on the treatment of all the more important diseases. It is designed for quick reference, and serves the purpose admirably and accurately. Though anyone may quibble over details of the treatments advocated, there can be little quarrel with the soundness and the general acceptance of the essential methods and procedures.

This is the type of book which is likely to be dog-eared by constant use. Those copies of earlier editions in libraries available to students are weary and worn before the next annual number appears. The great rapidity of development of drugs and methods in recent years has made frequent revision necessary. Each new volume shows much new material, but we are mildly amused by the editors apology that "some valuable information from the previous volume is necessarily repeated with only slight modification. It is obvious that radical changes in the therapy of certain diseases will not take place each year - -" for which we may say "Amen", and hope that we are still not "yet the last to lay the old aside."

J. I. W.

THORACIC SURGERY—by Richard H. Sweet, M. D.—Illustrated by Jorge Rodriguez Arroyo, M. D.—W. B. Saunders Co.—Philadelphia and London—Price \$10.00.

This book presents a resume of the very extensive experience of Dr. Sweet with thoracic operations. The emphasis is placed upon anatomical considerations and operative technique and, as explained in the preface, it is not concerned to any extent with pathological physiology or differential diagnosis.

It is interesting that the space allotted to diseases of the esophagus, and the operations indicated therein, is much greater than that afforded the various congenital and acquired cardiovascular diseases which have become amenable to operation in more recent years, but this is understandable in view of the much wider experience of Dr. Sweet with the former.

The illustrations are very clear, but there is no reference made to original works. As a book on operative technique, undoubtedly it deserves a place in the library of anyone concerned with any phase of thoracic surgery.

Edward F. Parker, M. D.

DISABILITY EVALUATION—Principles of Treatment of Compound Injuries. Earl D. McBride, J. B. Lippincott Company, Philadelphia. 1953. Price \$15.00.

The author of this book pioneered the field of disability evaluation, and in the present text keeps himself well ahead in the field. Through five editions, the work has been enlarged so that the fifth edition represents a very comprehensive coverage of the subject. It is in no sense a compendium. Since the first edition of 1936, the work has been the standard reference of physicians, lawyers and industrial courts, and the latest edition will continue to be a ready reference in formulating opinions in the evaluation of disability. The author emphasizes the importance of analysis in the evaluation of disability and suggests valuing the

percentage of loss of function in the light of the normal working capacity of the individual.

The variety and complexity of injuries are so infinite that it is difficult to establish a dogmatic schedule for rating the degree of residual disability and individual consideration is vital in every case. The part of the book dealing with approximate ratings, however, is very valuable and readily understandable. In its ratings are listed under almost any known type of occupation. The latest edition also, for the first time, gives a rating schedule on the disability of disease. A book of this kind takes some of the "guess work" out of disability evaluation, and places it on a more scientific basis. Since it is used quite widely it engenders conformity of opinion so that views of rating physicians will not be too divergent.

Thorough study of this book will greatly assist the average doctor to testify concerning disability with confidence and conviction.

John A. Siegling

LIVING WITH A DISABILITY by Howard A. Rusk, M. D. and Eugene J. Taylor—The Blakiston Co. Inc., New York, 191 pages, price \$3.50.

The authors have accomplished their goal in presenting to the disabled and family of the disabled much useful information as well as many devices and gadgets to make the essentials of living more convenient and easy. It is obviously not written as a textbook or reference manual but for the patient whose interests the authors have at heart. The material presented here will certainly eliminate many painstaking hours that were formerly devoted to one's personal needs and allow more time for a gainful occupation and pleasure. The presentation is precise and simply written in non-technical terms. The illustrations are precise and to the point.

Ritchie H. Belser, M. D.

AN ATLAS OF PELVIC OPERATIONS by Langdon Parsons, M. D. and Howard Ulfelder, M. D. Illustrated by Mildred B. Coddling—W. B. Saunders Co., Philadelphia 1953. Price \$18.00.

An excellent pictorial and textural compendium of the surgical procedures employed in gynecology including gynec-urology and gut surgery. The entire field is covered. The text is explanatory, not controversial, and is concise. The line drawings are clear. The reviewer believes more stress should have been placed on myomectomy and ovarian cystectomy and less on suspensions. It is probably the best American book on the subject, and would be very valuable to a resident or an interested general practitioner, but it should be emphasized that it is devoted to technique, not judgement.

J. M. Wilson

A HISTORY OF PSYCHOANALYSIS IN AMERICA, by Clarence T. Oberndorf. Published by Grune & Stratton, Inc., New York City, 1953. Price \$5.00. 250 pp.

The author, one of the founders of the New York Psychoanalytic Society in 1911, has been actively practicing psychoanalysis since that time and is a past president of the American Psychoanalytic Society. He is well qualified therefore by knowledge gained as an active participant in the development of psychoanalysis in this country to write of its history. That fact, plus an easy literary style make this an easily read, very rewarding book for anyone with an interest in the problems of emotional illness.

The author begins by brief reference to the history of psychiatry prior to the advent of psychoanalysis. What seems the first real "progress" in psychiatry was due to the efforts of such humanitarians as Pinel (1745-1826) in France, the Tukes in England, and

later Dorothy Dix (1802-1887) in America. There followed the descriptive era of Esquirol in France, Criesinger and Kroeplin (1856-1926) in Germany. Dynamic, interpretative psychiatry has been a development of the twentieth century, and towards its development, it is now generally agreed among psychiatrists, the contribution of Freud and other psychoanalytic workers has contributed most. Psychoanalysis is "(1) a system of psychology based on the knowledge gained through investigation of the unconscious processes of the mind; (2) the technique by which these processes are investigated, notably through the free association of ideas and the interpretation of dreams; and (3) a method of treatment intended to cure or alleviate abnormal emotional conditions which affect the functioning of the mind or body and usually both." Oberndorf traces psychoanalytic developments in this country from the probable first reference to Freud's work (Dr. Robert Edes in a lecture on "The New England Invalid" in 1895), through to the present when "psychoanalysis in one form or another has become firmly integrated with psychiatry, general medicine, psychology, and social work." A few of the landmarks in this development are: 1907: Adolph Meyer introduced dynamic (psychoanalytic) psychiatry at Manhattan State Hospital, 1909: Freud delivered a series of lectures at Clark University, 1910: James J. Putnam presented a paper, "Personal Experience with Freud's Psychoanalytic Method" before the American Neurological Association, 1911: New York Psychoanalytic Society organized by Abraham Brill, American Psychoanalytic Association organized later in same year, 1931: Franz Alexander became Visiting Professor of Psychoanalysis, University of Chicago, 1941: First psychoanalytic training institute under medical school auspices established at New York Medical College, 1945: Similar institute established as a post-graduate service at College of Physicians and Surgeons, Columbia University. But the book is not by any means a dry chronicle of events. There is a liberal sprinkling of personal, but pertinent, anecdote throughout and we get a definite impression of the personality of the author without the book becoming obtrusively autobiographical. Two of the more interesting of these anecdotes, early in his medical career, are given as illustrative of the background for his feeling of dissatisfaction with then current psychiatric practice and his readiness to try the psychoanalytic approach. In one he goes to the psychiatric ward of Bellevue late at night, by direction of his chief, to spurt cold Vichy water on the head of an hysterical. In the other, he feels as disappointed as the patient, (with a severe agoraphobia) when told by Dejerine that she simply must have courage. And there are many interesting sidelights on the personalities of leading figures in American psychiatry of the past half century. Oberndorf also essays a critical evaluation of some of the more recent trends in psychoanalysis, as well as an appraisal of Freud and his work, and an estimate of the overall value of psychoanalytic therapy in the author's experience. To this reviewer the candor of his evaluation is an engaging feature of the book. In an early chapter he gives a number of interesting quotations from precursors of Freud (among them Oliver Wendell Holmes, to a study of whose novels Oberndorf devoted an earlier book) which tends to place Freud's thinking in historical perspective. In numerous places he refers to the limitations of psychoanalysis, but in a summarizing appraisal he states his belief that, "no one can honestly doubt that psychoanalysis, since its introduction into America fifty years ago, has added each year to its credit a very great number of cures that prior to its advent would have resisted less understanding and intensive individual therapies."

DEATHS

DR. W. C. ROGERS

KINGSTREE, March 8—Dr. Wilson Chalmers Rogers, 67, died at his home here following a short illness.

After graduation he practiced medicine in the Dunbarton community for two years and then returned to his home in Indiantown.

For 40 years he served the people of his community, practicing medicine until his death.

DR. P. H. CULBREATH, JR.

Dr. Paul Hayne Culbreath, Jr., 48, died April 5.

Dr. Culbreath was a general practitioner and surgeon. He was graduated from Furman University and the Medical College of South Carolina at Charleston. He taught at the Medical College several years. He also practiced medicine in Ellenton for 17 years. He joined the staff at the State Hospital in 1952, where he served until his recent illness.

DR. WILLIAM A. WOODRUFF

Dr. William A. Woodruff, 77, Woodruff's oldest physician, died at his home after a week's illness, following a heart attack.

Dr. Woodruff was a native of Woodruff, which was named for one of his ancestors.

After graduation from the South Carolina College in Columbia, now the University, he received his medical degree from the South Carolina Medical College in Charleston in 1905.

Dr. Woodruff settled at Catechee in Pickens County, where he practiced for 15 years. He then returned to Woodruff, where he has made his home since.

Dr. Woodruff has been a member of the board of trustees of the Medical College of South Carolina since 1920, with the exception of two years, and was made an honorary member several years ago by an act of state legislature, with all the privileges of the regular trustees. He served two years in the state legislature from Spartanburg County.

Other positions held by him include president of the Pickens County Medical Association, past president of the Spartanburg County Association and former president of the 4th Medical Association, composed of Greenville, Spartanburg, Pickens and Oconee counties. He was a member of the American Medical Association.

DR. LUTHER W. BOGGS

Dr. Boggs had been in declining health for several weeks, and his death occurred at his home on Paris Mountain Sunday. He was a native of Pendleton, a son of the late F. C. and Hattie Watkins Whitten Boggs.

Dr. Boggs was a graduate of the Medical College of South Carolina at Charleston, and further pursued his studies at the Methodist Hospital, in Brooklyn, N. Y. He moved to Greenville in 1919 and had lived there ever since, except for two years spent in Battle Creek, Mich.

He was a member of the American College of Surgeons, the American Medical Association and the Greenville County Medical Society.

DR. RICHARD G. CHRISTOPHER

Dr. Richard G. Christopher, 90, retired physician of Landrum, died March 20 after several months of declining health.

DR. DAVID ROSS KENNEDY

Dr. David Ross Kennedy, 58, well known physician and a former resident of Due West, died at his home

in Paducah, Ky., March 23 following a sudden illness.

DR. JAMES HENRY MOORE

Dr. James Henry Moore, 87, died at a hospital in Milledgeville, Ga., after several years of declining health.

Doctor Moore, born and reared in Highlands, N. C., was a graduate of Emory Medical School. He practiced at Whitnire a number of years.

NEWS

ALPHA OMEGA ALPHA

The recently installed Alpha Chapter of South Carolina of the National Alpha Omega Alpha Honor Medical Society inaugurated its first annual Alpha Omega Alpha Lecture, on April 13, 1954, at 8:00 p. m., in Baruch Auditorium in Charleston.

To begin this series the Alpha Omega Alpha Chapter at the Medical College of South Carolina invited Dr. Wilburt C. Davison, Dean of Duke University School of Medicine, to address the Medical College student body and the Charleston County Medical Society on the subject of Sir William Osler.

Dr. Davison is a most eminent pediatrician and medical educator. He is a native of Michigan, was educated at home and abroad being graduated from Princeton, Johns Hopkins Medical School and Oxford, England where he was a Rhodes Scholar. His academic career has been divided between Johns Hopkins and Duke, where he has been Professor of Pediatrics and the first and only Dean of the School of Medicine. He has been the author of numerous articles and books on pediatrics and medical education. His talk on Sir William Osler finds him particularly qualified for this subject since, as a Rhodes Scholar at Oxford University, he knew Sir William Osler personally.

Following the lecture the Alpha Omega Alpha Chapter initiated its new members at a banquet.

Alpha Omega Alpha Initiates

SENIOR STUDENTS

Raymond Edward Ackerman

Ezra Kenneth Aycock

James Earl Barnett

William McKendree Barr

William Hall Lee, Jr.

Wendell Mitchell Levi, Jr.

JUNIOR STUDENTS

Joseph Ocran Beasley, Jr.

Walter Morse Bonner, Jr.

Margaret Bowen DeVore

ALUMNI

William Weston, 1897

W. A. Smith, 1910

Ben H. Wyman, 1915

T. A. Pitts, 1916

Leon Banov, 1917

O. B. Chamberlain, 1918

J. I. Waring, 1921

R. L. Crawford, 1923

Lawrence P. Thackston, 1924

Mitchell I. Rubin, 1925

Wynian King, 1927

Webb Haymaker, 1928

Cecil Wittson, 1931

Tom Peery, 1932

Frederick Dudley, 1938

H. R. Pratt-Thomas, 1938

Pearce Bailey, 1941

Howard Holley, 1941

Claude-Starr Wright, 1942

Pete C. Gazes, 1944

HONORARY

R. P. Walton—graduate of University of Chicago

WILLIAMSBURG COUNTY MEDICAL SOCIETY

March 3, 1954

The Williamsburg County Medical Society met at the A & J Restaurant, Hemingway, South Carolina, for its quarterly meeting on March 3, 1954.

After a delicious dinner, the following business was transacted. Dr. J. G. Ulmer was elected President. Dr. V. L. Bauer was re-elected Secretary and Treasurer. Dr. Paul S. Watson of Kingstree, was elected delegate to the South Carolina Medical Association with Dr. J. C. Montgomery of Kingstree as alternate. The Society also voted to put the magazine "Today's Health" in all High Schools of the county, colored and white. "Today's Health" is a publication put out by the American Medical Association which publicizes accurately all new developments in the field of medicine in a language that can be understood by students and average lay people. It also stresses the positive program of the medical profession to provide medical care to every person in the United States regardless of financial status.

The meeting was adjourned after a round table discussion on the South Carolina Medical Association convention to be held at Myrtle Beach in May.

V. L. Bauer, M. D.
Secretary & Treasurer

The Frank Hilton McLeod Memorial Scientific Assembly was held on March 18, 1954 at Florence, South Carolina.

The program included the following papers and a dinner at the Florence Country Club.

1. Post-operative Fluid Balance Dr. James Allen
2. Parenteral Fluids in Children Dr. Walter M. Hart
3. Safeguards and Pitfalls in Treating Injuries of the Upper Extremity

Dr. George R. Dawson, Jr.
4. Clinical Pathological Conference Dr. D. J. Greiner
Cardiac Surgery Dr. Otto C. Brantigan,
Professor Thoracic Surgery, Univ. of Maryland

The Coastal Medical Society met at Summerville on March 18th. Dr. S. Edward Izard of Charleston gave an address on "Arthritis."

Dr. Mike Watson plans to come to Bamberg upon completion of his internship at a Toledo, Ohio, hospital.

Dr. Ernest G. Edwards, who has been practicing in Savannah, Ga., for the past two and a half years, has opened an office at 1512 Gregg Street, Columbia for the practice of orthopedics.

Dr. Julius C. Burge has opened an office in York for the practice of general surgery. He will also be associated with Divine Saviour Hospital.

G. L. Cunningham, administrator of the Chester County Hospital, has announced that Dr. C. D. Leigh, surgeon, has arrived in Chester and started practice.

Doctor Leigh is a native of Valdassa, Ga., and was graduated from the University of Pittsburgh in 1940. He served his internship at the Allegheny General Hospital in Pittsburgh.

CHESTER MEDICAL CENTER

Chester's newest medical center, the Palmetto Clinic, has been opened in a modern new building on Columbia Street by Dr. Joe S. Redding and Dr. Harry G. Bagby.

HINSON IS HONORED BY COUNTY DOCTORS

Dr. Angus Hinson was elected president of the

York County Medical Society at a meeting held March 5 at Park Inn Grill.

Other officers named were Dr. Grover C. Sheppard of Fort Mill, vice-president, and Dr. Thomas E. Fitz of Rock Hill, secretary and treasurer.

Dr. Philip K. McNair, Jr., has recently returned from Washington, D. C., where he successfully completed oral examinations qualifying him as a member of the American Board of Pediatrics.

BIRMINGHAM, Ala., March 8—The president of the Southeastern Surgical Congress said today "99.44 per cent of our members, at least, are innocent" of fee splitting and "ghost surgery."

Dr. J. R. Young, of Anderson, S. C., made the comment in an address opening a four-day meeting of the group. About 1,000 surgeons were in attendance.

A. D. CUDDS NOTE 50TH ANNIVERSARY

Dr. and Mrs. A. D. Cudd were honored Tuesday, March 16, on their golden wedding anniversary.

More than 200 guests called during a reception held at their home.

Dr. Cudd, who celebrated his 82nd birthday has practiced medicine in Spartanburg for 58 years, and has been active in civic and professional organizations. He was co-founder of Good Samaritan Hospital, one of the forerunners of Spartanburg General Hospital.

INMAN PROJECT HONORS DOCTORS

Members of the Town Council have named the new housing project on Church St. Thompson-Miller Homes in honor of the late Dr. George E. Thompson and Dr. C. J. Miller who practiced medicine here for many years.

Dr. and Mrs. T. G. Goldsmith, Dr. Thomas Parker and Dr. Keitt Smith of Greenville attended the 11th annual meeting of the Association of American Physicians and Surgeons at the Hotel Heidelberg, Jackson, Miss., April 1-3.

Dr. Goldsmith, president of the association delivered his report Thursday at the noon meeting.

PACOLET MILLS COMMUNITY HONORS DR. DENNIS HILL

More than 500 persons assembled in this prosperous textile community to pay tribute to Spartanburg County's Doctor of the Year for 1953—Dr. Robert Dennis Hill.

Persons from Pacolet Mills, surrounding areas and Spartanburg paid homage to Dr. Hill, a general practitioner at Pacolet for 27 years, during a reception held for him at the Girls Club at Pacolet Mills.

Proof that Dr. Hill has served his community well during his long service record was evident by the number of persons who called to wish him well. He, with the exception of a few years has been the Pacolet section's only doctor within a 10-mile radius.

To most of the residents in the community, Dr. Hill has not only been their physician, he has been their family counselor with a willing ear for all their problems and troubles.

Dr. Hill was named Doctor of the Year at the annual meeting of the Spartanburg County Medical Society in mid-December. He is the fifth physician to be selected for the honor.

DR. ERGAS ASSUMES SUPERINTENDENCY OF CANNON HOSPITAL

The superintendency of Cannon Memorial Hospital, Pickens, has been assumed by Dr. J. S. Ergas, a native of Chile, who received his M. D. degree from the University of Geneva School of Medicine and has done postgraduate work at a number of universities.

A new, modern office building being built for Dr. John D. Thomas, Jr., on the lot adjoining the Loris Community Hospital means better medical service for the people of Loris and the surrounding area.

Dr. James McKnight Timmons, Columbia otolaryngologist, read a paper on "The Role of Plastic Surgery in the Restoration of Normal Function of the Nose" before the Columbia Medical Society.

CHARLESTON POLIO VACCINE TRIALS BEING PLANNED

The president of the Charleston County Medical Society said that the organization's membership will be canvassed for volunteers to participate in forthcoming trials of a polio vaccine among second grade school children.

Dr. Leon Banov said that a number of doctors volunteered their services at a meeting of the medical society. These, plus those canvassed, will provide a sufficient number to carry out the immunizations, Doctor Banov said.

The medical group already has given its unqualified endorsement of the vaccine trials.

Doctor Banov, County Public Health Director, who will supervise the immunization of 4,000 school children in the county, said today that the starting time for the inoculations will depend upon availability of the serum.

\$65,000 OCONEE HEALTH CENTER TO BE COMPLETED BY APRIL 15

Oconee County's public health unit personnel hope to be operating from their new headquarters soon.

The \$65,000 Oconee County Health Center, located on South Broad Street less than 200 feet from the courthouse is expected to be completed by April 15. The Health Department will move all its offices to the new building immediately thereafter.

SOUTH CAROLINA SURGICAL SOCIETY

The South Carolina Surgical Society met in Rock Hill on March 18 and 19. Thirty-four of the forty-two members of the Society were present. The opening session was held on the evening of March 18 at the Andrew Jackson Hotel with a dinner followed by an address by the guest speaker, Dr. Porter P. Vinson, Professor of Endoscopy, Medical College of Virginia, Richmond. His topic was "Appraisal of Surgical Procedures Employed in the Treatment of Esophageal Lesions." The following morning an operative clinic was held at the St. Phillips Hospital by the Rock Hill members of the Society. Following this, scientific papers were presented at the York County Hospital by the Rock Hill members of the Society. Two new members were elected to the organization, Dr. Robert Hagerty of Charleston and Dr. Irving Trencher of Spartanburg. New officers elected for the coming year are as follows: Dr. William C. Cantey, Columbia, President; Dr. Edward Parker, Charleston, Vice-President; Dr. J. Robert Thomason, Greenville, Secretary and treasurer.

WHITTEN VILLAGE BILL IS APPROVED

The State Training School for Mentally Deficient Children at Clinton gets a new name, Whitten Village, under a bill gaining final passage in the General Assembly.

The school was renamed after its long-time superintendent, Dr. B. O. Whitten.

Sen. Baskin of Lee County, chairman of the Senate Medical Affairs committee which proposed the measure, said the purpose is "to give the children at the school the feeling that they are residing in a community or village rather than a state institution."

He called the change "a very, very wise move," and

added that choice of name was logical because of Dr. Whitten's long service.

Dr. George Wilkinson, of Greenville, was the featured speaker at the recent meeting of the Anderson County Medical Society at the Country Club.

Dr. W. C. Bolt is president of the society.

Spartanburg's Board of Health by a 6 to 3 vote has again gone on record against fluoridation of this city's water supply.

As in the past, Dr. Sam Orr Black, board chairman, was principal spokesman for the opposition, while doctors and dentists—both groups locally, state-wide and nationally approve the move—spoke in favor. They are Dr. John M. Morgan, Dr. Higgins and Dr. J. G. Park, dentists; and Dr. George Preece, Dr. Charles H. Poole, Dr. Earle Poole and Dr. George Dean Johnson, physicians.

A NEWSPAPER TRIBUTE TO DR. GRADY CALLISON

The record established by the Health Department last month in serving no less than 12,000 individuals who called is one of those things that almost falls in the realm of a "believe it or not."

However the fact that you did perform that feat not only establishes a new mark for service rendered, but also reveals something of the vital importance of public health work in our community.

After having met that emergency in such fine shape the community can look forward with more confidence to the protection that it can anticipate, should some real health emergency threaten.

In the meantime, you and all of your staff are to be

congratulated for the magnificent manner in which you met the February challenge.

I know that it must have meant long hours, missed lunches, and no recreation at all for the entire organization.

But you have, without doubt, grown in the esteem of those you serve.

Colonel Anderson

MEETINGS ANESTHESIOLOGISTS MEET

The South Carolina Society of Anesthesiologists had their regular quarterly meeting at the Prince George Hotel in Georgetown on the week-end of February 13-14.

Members present were: Dr. John M. Brown, Dr. Richard Wayburn, Dr. John Doerr, Dr. West Simmons, Dr. Charles Poole, Dr. George L. Timmons, Dr. Richard Edmondson, Dr. Kenneth Bray, Dr. Kenneth Boniface.

The Society enjoyed a week-end meeting, the members being accompanied by their wives. We had a deep sea fishing trip on Saturday, which was not very productive of fish but very productive on good fellowship. On Sunday the Society held a business and scientific session. Dr. Kelley McKee of the Medical College of South Carolina addressed the Society on certain pulmonary function tests.

George L. Timmons, Secretary

The Southeastern Section of the Society for Experimental Biology and Medicine met at The Medical College of South Carolina January 22 1954. The program included papers by Drs. P. C. Gazes, Vince Moseley, R. A. Howell, K. J. Boniface, J. M. Brown, and R. P. Walton

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. David A. Wilson, Greenville, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

STUDENT LOAN FUND OFFICERS

The officers of the Student Loan Fund are the following:

Chairman: Mrs. David Adeock, 3325 Monroe, Columbia, S. C.

Co-chairman: Mrs. Sam O. Black, Jr., 197 Park Hills Dr., Spartanburg, S. C.

Treasurer: Mrs. Harry Davis, Jr., Sumter, S. C.

The officers of the Jane Todd Crawford Memorial Nurses' Loan Fund are the following:

Chairman: Mrs. Alton Brown, 904 Myrtle Drive, Rock Hill, S. C.

Co-chairman: Mrs. L. P. Thackston, Orangeburg, S. C.

Treasurer: Mrs. J. W. Tucker, 139 Janeway, Greenwood, S. C.

A. M. E. F.—WHY???

The medical schools of our country are badly in need of funds, and we of the profession are asked to help. The money for their continued operation must be found, and it can come only from government or private sources. Where federal subsidies are given, federal control always follows. Hoping to keep the medical schools free of government domination, the American Medical Association set up the American

Medical Education Foundation several years ago.

Each Auxiliary member is asked to contribute something to the fund this year, no matter how small. Individual gifts can be deducted from income tax under the usual limitations set by the Bureau of Internal Revenue. Many Auxiliaries have presented a memorial to honor some distinguished local physician. Auxiliaries can raise money by fashion shows, bridge parties, teas, or box suppers. Gifts may be earmarked for any particular school or put into the general fund for equal distribution to each of the 79 accredited medical schools.

Mrs. J. Harry Rogers, Atlanta
Southern Regional Chairman AMEF

DOCTORS DAY LUNCHEON SOUTHERN MEDICAL AUXILIARY

Mrs. A. T. Burnside of Columbia, Doctors Day Chairman, presided over the Doctors Day Luncheon held at the Atlanta Athletic Club during the convention of the Southern Medical Association and its Auxiliary in October. The Rev. John McSwen from Clinton, S. C. gave a delightful talk. Dr. William L. Pressly, of Due West, S. C. and Dr. J. M. Travis, of Jacksonville, Texas, were honor guests.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

MEDICAL PUBLIC RELATIONS*

The text of my remarks and one which sums up the state of our medical public relations, is a quotation of that sterling character in Stevenson's "Treasurer Island," Billy Bones, who says, "Doetors is all swabs."

Many of us have been increasingly disturbed of late by a deterioration of medical public relations. Painfully concrete evidence of this is the skyrocketing of your professional liability insurance rates because of an increasing recourse to litigation by malcontents. Pro Bono Publico writes more frequently and aeridly in the Letters to the Editor columns of the press deerying some real or fancied dereliction by the medical profession. To their credit our own medical journals have been foremost in condemning fee splitting, ghost surgery, and exorbitant fees, but these efforts to clean our own house have been taken up by the few sensation-seeking members of the press and their yelping has resounded out of all proportion to the true state of affairs. Politicians in seeking a seapegoat often singled out the cost of medical care as a chief cause of the high cost of living. It is natural that their allegations find ready credence with many.

Sickness and accidents are destructive and often catastrophic evils, inconvenient, disheartening, and expensive to the afflicted, and although the doctor may aid in the recovery or give comfort, he is nevertheless associated in the mind of the patient with a calamity. In only a few instances, as when a man gets new vision by glasses or a mother leaves a hospital with a baby in her arms, does the physician seem at best to do anything but return the patient to his former state. There is nothing to show for the receipted doctor's bill but a memory of an unpleasant episode. In fact "doctors' bills" has become a term which includes hospital expenses, drugs, roses for the sick room, and even loss of income while laid up. Of all these, however, the doctors' have been the slowest to rise in cost, and are proportionately less than ever.

Although the chance of recovery and speed of return to good health have been miraculously increased in the past generation out of all proportion to the total medical expense and especially to the doctor's charge, this is forgotten in the general discontent with his economic plight. What better whipping boy than Medicine? And it is only fair to say that in some instances the strokes are merited.

This public dissatisfaction with our craft is not new. Permit me another quotation: "Medicine is the most distinguished of all the arts but through the ignorance of those who practice it, and of those who casually judge such practitioners, it is now of all the arts the least esteemed. The chief reason for this error

seems to be this: Medicine is the only art which our states have made subject to no penalty save that of dishonour, and dishonour does not wound those who are compacted of it." This modern sounding comment was written more than 2,300 years ago and is ascribed to that Greek physician, Hippocrates, to whose oath most of us subscribed when we became doctors of medicine. In this same writing, "Law," he outlined the requirements of a practitioner of the art naming natural ability, place of instruction, instruction from childhood, diligence, and *Time*. Like wine and cheese a good doctor takes time in the making.

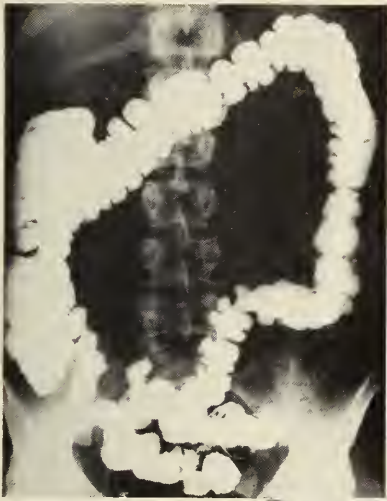
Of these Hippocratic requirements the possession of natural ability is determined by the student's own insight, by the competition of premedical training, and by the gantlet of aptitude tests and interviews which the candidate must survive. With this natural ability, with the opportunity to study medicine, and with diligence the student becomes a doctor of medicine, and on fulfilling the legal requirements is licensed by the state to practice medicine, to deal with life and death, to give counsel in some of the most profound human relationships, to be trusted as few men are. Probably a higher proportion of these young men, these newly licensed doctors, meet these tremendous tests which life will hold for them than does any other group of men.

The physician has a position which is unique in the trust, responsibility, and almost veneration which is given to the good doctor. His personal freedom and self employment are blessings known to few these days, although when the demands are great that these are blessings may seem debatable. This freedom and honor entail inescapable duties. Some forget this and accept the one but not the other.

We are doctors of choice, our own choice. The practice of medicine is still a calling, a consecration. Probably for this reason in the more than 2,300 years since Greek medicine advanced the art beyond the realm of the magician and the priest, there have been no penalties to keep the erring physician in order except an unwritten code of good form and the physician's own associates and guilds. It is not for the mercenary. All the great medical discoveries have been freely given to the world, to all doctors without copyright or profit. There are no national boundaries in medicine. Of all professions it alone strives to eliminate the source of its livelihood, to wipe disease, accidents, and human suffering from the face of the earth.

In the nature of things some doctors will fail to live up to their early ideals, some will become greedy, dishonest, unethical in their relations with their fellow doctors and with the public. To deny this would be to place man as high as the angels. What licensing board can foresee the future of the candidate? Which of these young doctors will stagnate, never be better

*Address by Dr. Alfred L. Potter, President, to the Providence Medical Association, January 4, 1954. (Reprinted by permission of the Author and the Editor, from Rhode Island Medical Journal, February 1954.)



Normal Colon



Ulcerative Colitis



Atonic Colon

Smoothage and Bulk in Correcting Constipation

To initiate the normal defecation reflex, the "smoothage" and bulk of Metamucil® provide the needed gentle rectal distention.

Once the habit of constipation has been established, due to any of a large number of causes, it becomes a major problem. Self-medication with irritant or chemical laxatives, or repeated enemas, usually causes a decreased, sluggish defecation reflex and may result in its complete loss.

Rectal distention is a vital factor in initiating the normal defecation reflex, and sufficient bulk is thus of obvious importance in restoring this reflex. Metamucil provides this bulk in the form of a smooth, nonirritating, soft, hydrophilic colloid which gently distends the rectum and initiates the desire to evacuate. Metamucil demands extra fluid, imparting even greater smoothage to the intestinal contents.

It is indicated in chronic constipation of various types—including distal colon stasis of the

"irritable colon" syndrome, the atonic colon following abdominal operations, repressions of defecation after anorectal surgery and in special conditions such as the management of a permanent ileostomy. Metamucil is the highly refined muciloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent.

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is supplied in containers of 4, 8 and 16 ounces. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

than the day he hung out his shingle? Which of these bright young men will develop mental aberrations, subclinical psychopathic tendencies which may not be overt enough to incapacitate but which will completely alter his outlook on society? Economic pressure may force some to sell out. His own health, physical or mental, may prevent his holding to the true course. As in Hippocrates' time, so today, dishonor is the only penalty for this. But dishonor by whom?

There has not been and there is not now an authority empowered to reappraise, warn, or when proper, deprive these failures of their privilege to continue to practice, unless they really break the law and are convicted. Only other doctors can appraise the professional competence of a doctor, but unless a man may fail of promotion or be dropped from the staff of a hospital, professional incompetence is not penalized except as reflected in his practice. He may continue to beguile a gullible public which is often unable to choose between the good and the bad doctor, and he may be a success economically. The public cannot judge, and ethics has properly sealed our lips as far as any criticism of the individual by individual doctors is concerned. A serious breach of ethics might deprive a doctor of his medical society membership, but unless he commits a felony such as drug peddling or commits an abortion, which under our rules of evidence is almost impossible of conviction, his license to continue in practice is not revoked. Once licensed, his position seems impregnable, and as for dishonor, as Hippocrates said, it does not wound those who are composed of it.

"An olde Proverbe says,
That byrde ys not honest
That fouleth hys own nest."

Like the cuckoo, which lays its eggs for other birds to hatch, these parasites are a burden on all honest doctors. We have protected these birds beyond all reason, we have condoned their malfeasance, and, to depart from our ornithological metaphor, now these few rotten apples in the barrel have given all the apples the same bad odor.

In 1816, Stephen Decatur proposed a toast: "Our country; in her intercourse with foreign nations may she always be in the right, but our country right or wrong." This has seemed to be our attitude toward every doctor, good or bad. I like better a change made by Carl Schurtz in Congress in 1872, "Our country, right or wrong: when right to be kept right, when wrong to be put right." Doctors have always been clannish, have a language of their own, live lives different from other men, and seem to go to great lengths to protect the erring guild brother from censure or discipline. It seems to me that we are now under a greater obligation than to a craft or guild. We are not in the Middle Ages. We must be citizens first of all and must stand up and be counted on the side of right.

Only his fellow doctors, it seems to me, can properly judge, and either condemn or exculpate a doctor. It seems that some procedure could and should

be found to discipline those few who prostitute our calling and bring us all into disrepute with the public, those few who falsify disability and insurance claims, give questionable evidence in drunken driving charges, who charge excessive fees, who operate for minimal indications, who split fees by some subterfuge or other and who are unethical in their relationships with other doctors. It is difficult for our association to be at once the prosecuting attorney, judge and jury. Your Committee on Ethics and Department is a most important way of getting redress of grievances by the public and by other doctors except for outright civil and criminal cases. It is a potent force for good in public relations, and the difficult unseen work of this committee merits our gratitude. It should be given more power and should be resorted to more often. Our Committee on Public Information is helping the press to know us better, and makes it easier to meet the proper demands of the press.

No Hogarth or Rowlandson now caricatures our profession, no Voltaire or Moliere holds us up to public scorn. Compared to them our present day critics are Lilliputian. It is interesting that we of later generations see that much of that harsh criticism was deserved. It may be so of us. We must realize that our emotions are stirred and that we are not impartial judges of the comment of our day. The press does praise our good works when it merits praise. And Stevenson who made Billy Bones say, "All doctors is swabs," wrote a tribute to our profession which puts us on so exalted a plane that we cannot read it without inward embarrassment unless we think of its being written of the great men in medicine, the Lazears, the Noguchis, the Schweitzers.

He wrote: "There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarelier still the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilization. Generosity he has such as is possible to those who practice an art, never to those who drive a trade; discretion tested by a thousand secrets, tact tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage."

That would have been a good peroration but I should not close leaving you smugly self-satisfied. Stevenson lived before our age of specialization, and he wrote those words not of the doctors in the laboratory carrying out the necessary and complicated techniques which have been the glory of and have brought the successes of modern medicine, nor of the specialists, necessary because of the increased complexity of our art, but about the doctor he knew, whom we call the "family doctor." He was the doctor most of us looked up to when we were young. There is a move to modernize this term, family doctor, as being old fashioned, by calling him "personal physician." In his own self-deprecating way he used to call himself, "just a family doctor," and the thoughtless accepted his self disparagement. The only good thing about this term, personal physician, lies in its



Specializing in the Treatment of Alcoholism

THE KEELEY INSTITUTE

447 W. WASHINGTON ST.

PHONE 2-4413

GREENSBORO, N. C.

REGISTERED WITH THE COUNCIL ON EDUCATION AND HOSPITALS OF AMERICAN MEDICAL ASSOCIATION

MEMBER AMERICAN HOSPITAL ASSOCIATION MEMBER NORTH CAROLINA HOSPITAL ASSOCIATION

recognition of the need and yearning which the patient feels for someone who will give him a continuing close doctor-patient relationship and will take on that unbroken mutual responsibility and affection. The general practitioner, the family doctor, had a most important advantage. He had a mutual acquaintance with, a neighborly understanding of, the daily lives of his patients, their antecedents, their everyday problems. A term has been coined to express a truism which the old doc took for granted, "Psychosomatic," which reminds us that the patient's emotions, worries, joys, disappointments, and fears are reflected in his bodily functions and physical ills. Our old-fashioned doctor was able to treat the whole man because he knew the whole man. He lived with him, watched him and his children grow up, was part of his community and his life.

The patient realizes the occasional need of a specialist in special circumstances, but resort to such counsel should not be, as it too often is, the unguided decision of the patient. The vast majority of ailments can be cared for by the good general practitioner. Too few people when well and of calm mind elect and select a doctor, a family doctor, a general practitioner, a personal physician to guide them in their medical problems. We should all encourage the public to return to this ideal. We should restore the prestige of the family doctor.

It is heartening to find more and more often among the medical students of today this aspiration to be good well-rounded general practitioners, eager to make their weight felt as doctors and citizens, to lead a full life.

This brings up another point in public relations. As citizens I believe doctors have been derelict. Their advantages of education and public trust should require them to take the leadership in public service in at least those fields touching medicine in which it is expected that doctors should be deeply concerned—air pollution, the condition of our parks and recreation centers, juvenile delinquency, the contamination and filthiness of our rivers, waterfronts, and beaches, contamination of shell-fish and other foods, and an interest in our educational problems. The doctor must come down from his ivory tower into the streets and market place. He must become the outstanding citizen he used to be and again take part in neighborhood activities, local politics, the church, and education.

In conclusion, to try to regain the good medical public relations which the past generations of doctors enjoyed:

1. We must return to the ideals which were ours when we entered Medicine; we must rededicate ourselves to service.

2. We must more closely follow the letter and the spirit of our professional code of ethics both as to fellow doctors and the public. It was designed for the welfare of the public, the patients.

3. We must be less resentful of honest criticism and look for its causes.

4. We must protect the public and ourselves from

the doctors among us who are not worthy of their calling by bringing our own delinquents before boards of review.

5. We must help the general practitioner to be better recognized by the public, and restore him to his irreplaceable place in Medicine.

6. We doctors must write and enforce stricter laws of conduct than the law currently demands or the pressure of public opinion will make the law take over.

AN INVITATION TO FRANK DISCUSSION

Dr. W. L. Portteus, Franklin, Ind., has prepared and gives to all his patients, a small six-page folder containing a frank explanation of services and fees. The same message which appears on the A. M. A. plaque inviting patients to discuss these matters is carried on the cover page of the folder. This and the text of the remaining five pages of the folder reads as follows:

To All My Patients

I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between physician and patient.

As Your Physician—I believe the misunderstandings about the payment of medical bills can be avoided if fees and services are discussed in advance.

It is always my intent to explain fully to each patient—but there may be occasions when I may not fully anticipate the questions which may be foremost in your mind. I hope this pamphlet will assist you in having a better understanding of my services and fees.

If There is Doubt—in any manner in your mind about the charges for your care, please ask me. We will both benefit by a frank discussion, and I want you to feel free to discuss your financial situation with me, if such is your desire.

My Fees are Based—not only on the time spent with you and the nature of your illness, but also upon the time which will be required in making necessary arrangements for your surgery, and the care required until you are again well and feeling like yourself.

So You May Understand—better the cost of your care, and know of the many details involved in preparing or providing the best care, I ask that you read carefully the following. If you have any questions after you read this pamphlet—please remember, I want you to ask me so a complete understanding may be had.

Your Care Will Require the Services of a Team—Surgical treatment requires the services of a team of highly trained specialists—all skilled in your particular responsibility. Not only will I, as your physician, be in attendance, but also a surgeon, an anesthetist, several nurses and in some cases an assisting surgeon.

Costs vs. Security—For your security many examinations and tests will be made. Guess work has been removed in giving you the best medical care in the world today. Laboratory tests and x-rays may be

needed to determine the reactions of your body and in helping to establish a diagnosis. Also, in case extra blood is required, this too, will be on hand for immediate use and many other security measures which you may not see—or these, there will be charges.

The Hospital—will bill you for the services furnished by the hospital. These usually include your room, board, nursing care, laboratory tests, x-ray, use of operating room (which includes payment for sterilization both prior and following your surgery, of the room, garments, uniforms, linens, instruments, etc.) They will usually bill you for oxygen, drugs and other hospital services administered while you are a patient. (The number of laboratory tests and x-rays will vary according to the type of case and unforeseen complications and usually it is not possible to give you an exact estimate on these items.)

Your Surgeon—who is highly skilled and well-trained, and who will be in charge of your surgery will bill you for his services.

The Anesthetist—who has had special training in administering the many modern anesthetics, will charge for his services. The charge which will be shown on your hospital bill for anesthesia is for the materials used and appliances furnished by the hospital and does not include the physician's fee.

The Assisting Physician—In most cases of surgery an assisting physician or surgeon is required. While this may seem unnecessary, and added expense—it is

for your protection. Added skilled assistance makes for speedier and safer surgery. You will be billed for this service.

Your Insurance Plan—If you have a hospital and surgical insurance plan it should be carefully studied in order that you will know in advance how much of your total bill you insurance will cover. I will be glad to help you prepare an estimate of your total charges as well as how much of these charges your insurance will provide for. I would suggest that you bring your policy with you for this discussion.

Your Family Physician—As your family physician my charges will include: my services rendered prior to your entering the hospital; the calls I will make on you while you are hospitalized, which may be only one or several in a twenty-four hour period; the time and expense of making arrangements for your surgery and hospital admission and for the care required in your illness until you are enjoying a good recovery.

I may be the anesthetist or the assisting physician during your surgery.

It is Difficult—to explain every move and every service which is necessary to provide this care for you and keep it in brief form. I hope you will find this helpful in giving you a better understanding of the services which you will receive and the charges for these services.

Again, I invite you to discuss these matters with me, frankly, as it is my desire that you have complete

ATTENTION RESIDENTS — INTERNES

**ARE YOU CONTEMPLATING ENTERING PRIVATE PRACTICE SOON?
WE CAN EQUIP YOUR OFFICE COMPLETE. THE FOLLOWING ON
DISPLAY—**

CONSULTATION ROOM FURNITURE
EXAMINING & TREATMENT
ROOM FURNITURE
SHORT WAVE DIATHERMY
SCIENTIFIC EQUIPMENT



DIAGNOSTIC EQUIPMENT
LABORATORY SUPPLIES
SURGICAL INSTRUMENTS
FRACTURE EQUIPMENT

We invite you to our stores. Let our SPECIALLY TRAINED PERSONNEL help you make your selection. SEE what you BUY, BEFORE you BUY IT.

VISIT US AT YOUR CONVENIENCE. WRITE, WIRE or TELEPHONE IF YOU DESIRE NIGHT or WEEKEND APPOINTMENT.

COMPLETE stocks of HAMILTON, NU-TONE, NU-TREND and STEEL-TONE.

We service what we SELL. Terms to suite everyone.

**W i n c h e s t e r**
CAROLINAS HOUSE OF SERVICE

Winchester Surgical Supply Co. **Winchester-Ritch Surgical Co.**
119 East 7th St. Tel. 2-4109 Charlotte, N.C. 421 W. Smith St. Tel. 5656 Greensboro, N.C.

information and understand fully all details in our caring for you.

Sincerely,

W. L. Porttous, M. D.

THE LEGACY OF A GREAT PHYSICIAN

Walter Cane, M. D.

Edward D. Spalding, M. D., Editor of the Detroit Medical News, a brilliant clinician and a forthright leader of the medical profession in his city, in his state, and in the nation, was shot and killed when leaving his office to attend the December 1953 meeting of the A.M.A. House of Delegates in St. Louis. It was Monday, November 30, and on the same day the Detroit Medical News received from "Ed" Spalding the following article for publication. It appeared on the Editor's Page of its December 7, 1953 issue,—on the opposite page was his obituary, showing their, and our irretrievable loss. Prepared as a simple editorial, the (following) words have become this great man's legacy to the medical profession, his parting words.

The Manners of the Profession*

Today a great deal of money and effort is being spent on "public relations" to create a better feeling toward the Doctor. But every physician in his own office has within his power many times each day, the most effective instrument of all to create and sustain a favorable attitude toward the profession. If this is properly used, counter-influences will be of slight avail—and if not so employed, all other efforts will amount to little.

The cornerstone on which all medical practice rests is that of *personal service*; intelligent and kindly individual attention. Medicine as a science has made prodigious strides in the last half century, and yet it seems the more we progress as scientists the more impersonal we become. These two attitudes however are in no sense incompatible, and proficiency in the one in no way requires neglect of the other.

One starting point of this unfortunate and wrong attitude on the part of many doctors is in the medical school itself. The young men on entering are continually presented with the abstract facts of advancing medical science, but little attention is given to their basic application for the relief of human ills. The patients in the wards are just so many exhibits of this or that interesting pathological condition—examples of problems in perverted physiology waiting to be solved. The human element is largely overlooked. So when the young physician starts in practice, unless he has preserved a basic feeling of service to his fellow man he soon finds himself engrossed in the economic problems of making a living, and commercialization of his practice is a very easy transition unless his basic ideals have been soundly established.

In years past when the apprentice system prevailed, the young physician starting out had more of an op-

portunity to observe the professional habits of his senior colleagues in their dealing with patients, and their manners developed through long years of practice. Today the medical student is first saturated with all the latest scientific developments pumped into him in medical school. He is then presented with thousands of proprietary medications furnished him by the pharmaceutical houses, delivered with all the pressure of modern advertising. It is no wonder that soon he is apt to find himself doing a "land-office business" on a purely commercial level.

But this is not the practice of medicine as it should be. In the conduct of a practice the physician, in addition to his intelligence and scientific skill, should give something of himself to each patient whom he serves—a *kindly personal human interest*. This is the leaven in the bread that makes the whole loaf of scientific knowledge rise, and without which technical facts become cold fare indeed. It is the lack of just this element which is one of the fundamental faults of the medical profession today, and the reason for much of the social unrest and dissatisfaction with medical service as it is now offered.

The remedy lies not in public propaganda, published articles, and radio broadcasts, but in the consulting room of every doctor, and how he deals with each and every patient that he sees.

WHITTEN VILLAGE

B. O. Whitten, M. D., Superintendent
Clinton, S. C.

Institution with above title has good position to offer as Clinical Director to young, capable physician, preferably a South Carolinian but not necessarily. Person logically succeeds to Superintendency in few years, or refuses that office at his discretion. Anyone interested, communicate with the undersigned.

B. O. Whitten, M. D.
Superintendent

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

(NOTE: The above is too fine to escape the attention of any physician. The circumstances of its original publication are outlined in the following, which appeared over its reprint in the Nassau Medical News, February, 1954.)

The Journal of the South Carolina Medical Association

VOLUME L

June, 1954

NUMBER 6

Factors Influencing Maternal Mortality in a Rural State

ROBERT A. ROSS, M. D.,*

Chapel Hill, N. C.

It should be of interest to compare the maternal morbidity and mortality of North Carolina with those of a Sister State. It is trite to say that the health and life of an individual or group of individuals cannot be assured by medical care alone; however, it is true. It is also true, to repeat the old medical homily, that medicine is not an exact science. The vagaries of the "medically inarticulate," the geography, the sociologic conditions and other factors all are important. Medically, the accessibility of doctors and hospitals, publications, medical schools and medical centers, however small, nurses and health agencies do help save mothers and babies.

To dwell on familiar ground may we mention a state that has only one city of more than 100,000; whose population is 4,000,000 and has, until recently, hospitals in only 50 of the 100 counties. This state at some time has had 8 medical schools, but the oldest survivor is only about 70 years old. One institution (Wake Forest) in 1858 was second only to Yale University in endowment, yet it was only in 1940 that she could establish a 4-year medical school. The State University has had 3 medical schools; the present 4-year school having been opened in September, 1952. Duke University, through private philanthropy, was created in 1930. We all know of its remarkable rise in excellence in 22 years. These facts are presented simply to illustrate the importance of economic backing. The father of Mr. Duke

started his fortune by selling tobacco to Sherman's soldiers who were quartered in Durham. Wake Forest received the majority of its funds from one of the Reynolds Tobacco officials, Mr. Bowman Gray, and the rest from a devoted and devout Baptist citizenry of North Carolina.

These factors delayed medical education and were reflected in maternal mortality and morbidity. The State University was closed during the Civil War and Federal cavalry horses were quartered in its old buildings. It has taken the state a long time to recover from the exigencies of a terrific war and prolonged period of occupation. This is easily understood when one recalls that this state had more men under arms than the total of male voters. Yet this is a state that had an established Medical Society in 1799. Its only means of publication and dissemination of information was the Philadelphia "Repository." The mention of publications recalls Crawford W. Long reporting his experiences with ether in a rural Georgia journal, and that of the Virginia gynecologist, Mettauer, who reported several successful operations for vesicovaginal fistulas using metallic sutures (lead), and how these published articles were either not seen or disregarded by other eminent men. So the lack of an articulate and widespread press did slow the progress of this area.

Even though the mentally and financially able people of the South were motivated only by the most selfish instincts, they would realize the necessity of preserving the health and competency of this needful class. It is well recognized that these thirteen million persons

* (From the Department of Obstetrics and Gynecology, University of North Carolina, School of Medicine)
Read at Medical College of South Carolina, Post-Graduate Seminar, Charleston, S. C., November 5, 1953.

are the greatest and probably the last source of man-power reserve. As a matter of fact, the thoroughly altruistic, capable leaders have since colonial days taken a genuine and helpful interest in these people. This has continued and progressed even through the devastation and misery of the Civil War. The enlightened class had not only to strive to survive themselves, but also to carry the less fortunate through all kinds of political, sociologic, and especially economic discrimination. The resulting rancor and bitterness are still manifest in the more stupid class of white people. The triad of "ills" is familiar.

The gradual progress and enlightenment must be viewed with mixed emotions until the process is complete. Already we know that criminal abortions and homosexuality are increasing in the Negro. The latter is a disturbing moral and mental factor in any group, and the former is bound to be an exacting factor in a people improperly nourished and already prone to infection. The stoicism, naturally happy and misunderstood disposition and zeal for life, give a false sense of well-being. Malnutrition, infection, anemia, tendency to cardiovascular disease, and environment are the more pertinent factors. The Negro and the undernourished actually belie the generally accredited ability to "take it" obstetrically and surgically. We believe that once these women are admitted to a recognized hospital their treatment is comparable in competency to that of other localities. Certainly in our institution, the house staff soon learns that the pathology and chance for learning are in this class patient, and the "private" patient is passed over in order to stand by the patient with "real pathology." Bradford¹ has insisted that the rural patient cannot be compared on a fair basis with her urban sister. The only consistent factors are poverty and sickness and McCord⁵ has wisely said that uniformly good obstetrics cannot be given these women, when such care is measured in terms of professional service alone.

In a study of the years 1932 to 1936 the maternal mortality figure was 7.1 per 1,000 live births, with the toxemias accounting for approximately one-third of the deaths.

Hamilton³ studied 1,396 maternal deaths in

North Carolina as related to the time of pregnancy that the pregnant woman first consulted a doctor, and found that 82.4 per cent of the total had some complication of pregnancy or concurrent disease when they first saw their physician, and that only 17.6 per cent reported for examination when they were presumably well. "If we assume that adequate prenatal care must begin before the end of the fourth month of pregnancy, 5.2 per cent gave their physician a fair chance to give them protection. In a second report, approximately 9 per cent of the small number included in that study reported to the physician before the end of the fourth month. It is evident that we have not yet made progress in our efforts to provide adequate prenatal care to those of our citizens who are creating new life."

Cooper,² in his year's (1946) summary, states that in 1937 only 15.5 per cent of all births were in a hospital; in 1944, 51 per cent of the total births occurred in hospitals; and that 84.3 per cent of women who received E. M. I. C. care were delivered in hospitals (over 12,000). Lately, the picture has brightened. In North Carolina the total maternal mortality for 1941 to 1945 was 3.3 per cent and for 1945 alone was 2.5 per cent. This, together with the low infant mortality of 43.4 per thousand live births, is most heartening.

Mauzy⁴ has recently studied the maternal deaths that have been reviewed and evaluated by the Maternal Welfare Committee developing some remarkable facts.

The North Carolina Maternal Welfare Committee has functioned continuously since 1946. It is gratifying to know that in 1949, during its fourth year of operation, the maternal death rate dropped to 11.8 per cent per 10,000 and, in relation to other states, North Carolina had moved from forty-first to thirty-fifth. Among the southern states, only Virginia had a better record than North Carolina.

During the five year period surveyed, 70 per cent of all live births were from the rural areas and the nonwhites accounted for 31.6 per cent.

The significant increase in hospital deliveries is apparent, but there is a marked disparity between the whites and nonwhites. The midwife still accounts for over one-third of the

nonwhite deliveries.

North Carolina has more nonwhite births than any state except Mississippi.

Of the 1,000 maternal deaths reported to the Committee, 844 were due to obstetric causes; 349 of the women who died were white and 459 nonwhite. One-fourth of all the deaths occurred in the home. The youngest mother was 13 and the oldest 46 years of age. Ninety-two per cent of all obstetrical deaths in North Carolina during this study have been judged preventable.

Two hundred fifty-nine deaths were assigned to hemorrhage. Of this total 98 who died were white and 161 nonwhite. The physician failed to diagnose ectopic pregnancy in 32 instances and only one patient in this group was operated upon. The failure of the doctor to diagnose ectopic pregnancy or procrastination in his treatment is responsible for one-eighth of all deaths resulting from hemorrhage. The 12 deaths assigned to errors in judgment were in the main caused by internal podalic version for placenta previa.

In the deaths from infection the patient was directly responsible in 300 cases which include all the criminal abortions where she failed to seek help. The midwife was responsible in 9 cases through poor technique and failure to refer the patient.

There were 25 deaths due to anesthesia in this group, 15 white patients and 10 nonwhite. Spinal anesthesia was responsible for 9 deaths; surgical doses were generally employed in all cases and at times the drug was injudiciously used in toxemia.

Preventable factors are present in 92 per cent of 844 obstetrical deaths. The Committee has judged a death preventable under ideal conditions which may penalize the physician. Of the two hundred and sixty women who died from the toxemias, 102 were white and 162 were nonwhite. One hundred and sixty had true eclampsia and 25 pre-eclampsia. The remaining patients had cardiovascular disease or some type of nephritis. The toxemias probably represent the greatest problem in this area and should be given emphasis.

With no sharp demarcation there are three dietary groups of patients in North Carolina: (1) the intelligent economically capable, (2)

the fairly cooperative, adequately nourished, and (3) the uninformed, improperly nourished, medically inarticulate group. We have rarely found toxemia in the first two, but it is the prime factor in maternal mortality in the last.

We⁶ feel that the subsoil of toxemia of pregnancy is, paradoxically, prepared by improper dietary habits, usually lack of certain vitamins, minerals, and proteins, and by improper fluid intake and output. In our area such a patient would develop pellagra if exposed to the sun and, we feel, may develop symptoms of pregnancy toxemia if she becomes pregnant and does not present herself for treatment. Some of our findings are given in support of this thesis. Whether simply parallel or actually causative is of little moment, when we realize that medical care will dispel the problem.

The nearest approach to a control study is on the patient who is admitted with evidence of toxemia and who under diet, sedation and elimination is controlled but for some reason insists on leaving the hospital. The return to familiar domestic and dietary habits invariably leads to readmission, usually with more alarming symptoms.

On checking the localities from which our toxemia patients have been referred, and on reviewing the state morbidity and mortality statistics, we have found that in the same areas in which eclampsia occurred most often, we were likely to find a large percentage of pellagra and similar diseases. On close and repeated questioning and investigation we found that the patient that we see in eclamptic convulsions has come from the same group who subsisted on a diet similar to pellagrins. The diet is grossly deficient in all the vitamins, especially A, C, and D, as well as being inadequate in minerals. The energy-producing elements are adequate as a whole, but there is a protein deficiency. The animal protein consists chiefly of pork, which varies with the season. It is over-abundant in the fall and winter, but inadequate in the summer. The largest proportion, estimated as 70 per cent, of the protein in the diet was furnished by the cereals and only approximately 30 per cent by meats, milk, and eggs. It is conceivable that, while the total amount of protein was adequate, the

quality of the protein, or the quantity of the type of protein best suited for replacement of maternal tissue and blood proteins, was not entirely adequate. This possibility was born out of the discovery of the relatively low plasma protein values. Also, on the basis of our knowledge of the group of the population from which most of the patients came, the dietary was very likely to have been deficient both in the quantitative and qualitative aspects.

Aside from our own efforts in prevention and salvage of toxemia patients, it is gratifying to see the general purposeful efforts toward better prenatal care throughout this area. This state has for years sponsored lectures and refresher courses. The Board of Health has been especially helpful in checking birth certificates with female deaths and in having the county nurse furnish additional information when the facts were vague or inconclusive. The state Medical Journal kindly allotted a page to the Committee, and each county medical society appointed a representative to confer with members of the Committee. In order to reach all citizens of the state, to inform them on health matters, and to provide facilities and personnel, a "Good Health" program has been instituted. Wise and humanitarian governors and legislators have listened to the enlightened doctors and now have under way a program

which should largely eliminate the menace of toxemia of pregnancy, the nutritional and other diseases which plague those who do not have recourse to medical care. Among the provisions are loans for medical students, utilization and coordination of all teaching facilities, utilization of all hospitals for intern and resident training, and rotation, peripheral post-graduate training, improvement of laboratory service, provision of consultation service, coordination of state-wide medical care, integration of public health and medical education, building of hospitals where needed, and the alternate use of "Health Centers" where hospitals are not feasible. Such a program has particular appeal to the South and its traditional "States Rights" stand. It places squarely on the state its responsibility of aiding in the "ill" among its citizenry, a citizenry not recently favored by Federal grants and with notable exceptions, private philanthropy.

BIBLIOGRAPHY

1. Bradford, W. Z.: Proc. N. C. Hosp. Association, p. 50, Apr., 1934.
2. Cooper, G. M.: Yearly Report, Maternal and Infant Welfare. N. C. Board of Health. 1946.
3. Hamilton, J. H.: Tr. Med. Soc. State of N. C., 1937.
4. Mauzy, C. H.: Tr. Fifth Am. Congress on Obst. and Gynec. (Supp. Vol. Am. J. Obst. and Gynec.) 64A: 214, 1952.
5. McCord, J. R.: Tr. Amer. Assoc. Obst. Gynec. and Abd. Surg., Vol. LII, p. 1-10, 1940.
6. Ross, R. A., et. al: Amer. J. Obst. and Gynec. 35: 426, Mar. 1938.
Ross, R. A., et. al: Amer. J. Obst. and Gynec. 66: 1113, Nov. 1953.

Central Causes of Vertigo

E. CHARLES KUNKLE, M. D.

The neurologist's interest in vertigo is a practical one: the symptom is always distressing and often incapacitating, and it can be of prime localizing value in certain disorders of the central nervous system. In the brief analysis of these central disorders which follows, derived in part from past reviews,^{1, 2} it is assumed that the symptom in question has been properly identified as true vertigo. It must be conceded that this decision is sometimes extraordinarily uncertain in inarticulate, unintelligent or suggestible patients.

THE APPARATUS

The neural network which participates in vertigo of central origin is shown diagrammatically in Figure 1. The end organs for equilibrium in the semicircular canals, the utricle and the saccule are eliminated from consideration here. The primary vestibular neurones, bipolar cells in Scarpa's ganglion lying in the internal acoustic meatus, are transitional between peripheral and central structures but will arbitrarily be considered central. Vertigo can arise from irritative or destructive lesions in the variety of structures illustrated in the diagram: the vestibular ganglion and nerve, the vestibular nucleus in the brain-stem at the pontine level, the vestibulo-cerebellar tract to deep central portions of the cerebellum, the medial longitudinal fasciculus integrating eye and neck movements, and the final stations for perception of movement and position in the temporo-parietal area of the cerebral cortex. The exact path employed from brain-stem to these last centers for awareness is not clearly determined, but the thalamus undoubtedly lies on the route. The vast majority of instances of central vertigo arise in disease of the pontine area involving one or both vestibular nuclei and their local connections. In essence, vertigo results

when false information from these diseased structures reaches consciousness, and does not coincide at this level with accurate data concerning the body's orientation sent in from other sense organs (visual and proprioceptive). The vestibulo-spinal tracts, emerging from the lateral portion of each vestibular nucleus and descending in the anterior portion of the cord (together with other outflow tracts of the cerebellar system not shown in the diagram), probably affect some of the reactions to vertigo, such as lurching, listing and past pointing, but are not in themselves sources of vertigo.

DIAGNOSTIC FEATURES

The principal diagnostic features of vertigo of central origin which help to distinguish it from vertigo of labyrinthine origin are summarized in the table below. Emphasis is here placed upon the value derived from attention to certain symptoms and signs other than vertigo itself.

	<i>Labyrinthine</i>	<i>Central</i>
Sensation:	Usually rotary	More variable
Timing:	Episodic	Sustained
Tinnitus &	Common	Uncommon
Deafness:		
Nystagmus:	Fine or coarse, fast	Coarse, slow
	Horizontal or rotary	Rarely rotary
	Never vertical	Sometimes vertical
Caloric Responses:	Normal, hyperactive, hypoactive or absent	Normal, hypoactive or absent
Other Neurological Abnormalities:	None	Common

The fact that vertigo is accentuated by head movement is not in itself of definite localizing significance, for this feature may accompany either labyrinthine or brain-stem disease.³ Acute vertigo precipitated by head movement, and accompanied by headache and vomiting in a patient who tends to carry his head antero-flexed and sometimes slightly rotated, suggests Bruns' syndrome.⁴ This special group of symptoms and signs may indicate the presence of a tumor within the fourth ventricle or, less commonly, of the vermis of the cerebellum

From the Department of Medicine (Neurology) Duke University Medical School and Hospital, Durham, N. C.

Presented at the annual joint meeting of the North Carolina Eye, Ear, Nose and Throat Society and the South Carolina Society of Ophthalmology and Otolaryngology, at Charleston, S. C., September 16, 1953.

or in the third or lateral ventricles. Very rarely it may be encountered in multiple sclerosis.

COMMON CLINICAL ENTITIES

The important causes of central vertigo can be classified in terms of their location as follows:

I. *Pontine Lesions*.—Four major disorders can affect this crucial zone:

- A. Vascular lesions
- B. Rhombencephalitis
- C. Tumor
- D. Multiple sclerosis

* A. Partial or complete occlusions of any of the arteries nourishing the pons and adjacent areas may produce central vertigo. The posterior inferior cerebellar artery is customarily considered first in this connection, but other branches of the vertebral or basilar artery may be concerned. The decision as to the exact locus of the resultant infarct is based upon the nature of the associated symptoms and signs and is largely of academic interest only.

B. The etiologic agent in most instances of inflammatory disease of the brain-stem, conveniently termed rhombencephalitis, is rarely detectable.⁵ The symptoms and signs in addition to vertigo are variable, fever may be present and the spinal fluid often shows an increase in cell count and protein.

C. Tumors of the brain-stem are almost always infiltrating gliomas, progressive and inaccessible to surgical removal. Accurate differentiation of this group from vascular and inflammatory lesions is sometimes impossible early in the course of the illness. The diagnosis becomes apparent as the disease relentlessly progresses, particularly if signs of block to cerebrospinal fluid pathways eventually develop.

D. Multiple sclerosis produces vertigo only during an exacerbation of the disease. Associated symptoms and signs may at first be minimal, and the true diagnosis may be delayed for many months or even years if the illness is of the benign type and unfolds slowly.

Streptomycin, in the moderate dosages now employed, infrequently affects vestibular pathways with sufficient severity to produce vertigo. Part, at least, of its occasional toxic action

is upon the vestibular nucleus. Syringobulbia and platybasia are two chronic neurologic disorders occasionally productive of vertigo, although other symptoms and signs are usually more striking.

II. *Para-pontine Lesions*.—Tumors of the cerebello-pontile angle almost always arise as benign neurinomas of the eighth cranial nerve. Vertigo with this lesion is usually low-grade and fluctuating, almost never severe and paroxysmal. Far rarer in this group are granulomas close to the brain-stem, as from infection with syphilis, tuberculosis or torulosis; aneurysms of the basilar artery or certain of its branches; or tumors of the fourth ventricle or cerebellum.

III. *Cerebral Disorders*.—Vertigo is occasionally part of the aura of a migraine attack or of an epileptic seizure; the subsequent symptoms usually point to the correct diagnosis. When vertigo is a symptom of a cerebral tumor, it is rarely intense or paroxysmal. Although it is more common with tumors lying close to the temporal lobe, the vertigo of brain-tumor is not of dependable localizing value.

IV. *Post-traumatic States*.—Vertigo is a fairly frequent sequel to head injury, particularly that of concussive type with brief or prolonged loss of consciousness. Its origin is far from clear and it may well be labyrinthine in some individuals and central in others. The symptom usually subsides spontaneously within a few days or weeks. If it persists for many months in the absence of clear signs of structural damage to the inner ear or brain, a psychologic origin is probable.

V. *"Reflex" From Neck Disease*.—It has been suggested that vertigo often arises from structural disease of the neck, involving either muscles and ligaments or the vertebrae and adjacent roots and spinal cord.⁶ Evidence concerning this mechanism is remarkably scant. It is relevant, however, that Simons and Wolff have noted a few patients with post-traumatic headache in whom exacerbations of pain accompanied by vertigo were produced when the head was flexed forward.⁷ In these, vertigo was also experimentally induced by painful pressure upon tender regions in the deep tissues at the base of the skull. Pain and vertigo were eliminated by the local injection of

1% procaine into the tender areas. These authors therefore postulated that vertigo of this type may arise from a spread of noxious impulses entering the brain-stem from the neck and secondarily exciting the nearby vestibular nuclei. The hypothesis remains tentative and probably applies only to a small minority of post-traumatic vertiginous disorders.

VI. *The Issue of "Vestibular Neuritis."*—Appropriately placed near the end of this list because so little is known of the mechanism and site of origin, is a common form of vertigo, acute in onset, benign in course, and occasionally epidemic in distribution. This disorder is sometimes preceded by a respiratory or other systemic infection; hence the usual assumption that an infectious agent, probably viral, is responsible. The vertigo is often easily accentuated by head movement. It may subside completely within a few hours or clear gradually after several weeks. Nausea, vomiting and nystagmus may be noted during acute episodes of vertigo but tinnitus and deafness are absent and examination is unrevealing except for mild reduction in responses to caloric tests in some instances.

This syndrome has commonly been classified as a "labyrinthitis" despite the lack of any clear clinical or pathologic justification. An alternative assumption is that the lesion lies in the neurones of the vestibular ganglion or in the vestibular nuclei of the pons.⁸ Dix and Hallpike have recently supported this explanation, postulating a "vestibular neuritis."⁹ Since the patients resolutely recover, however, the disease site will probably long remain in doubt. The exact nature of the lesion or lesions is even more conjectural.

VII. *Psychogenic Disorders*—In its broadest meaning, psychogenic vertigo is any related directly or indirectly to an emotional disorder. Thus defined, the vertigo of migraine and Menière's disease may be included here. Vaso-motor changes in the neural apparatus for equilibrium, either within the labyrinth or in the brain-stem, have been postulated to explain the symptom in these two disorders, but the areas in question are inaccessible to view and the rate of blood flow within them cannot be measured.

There is, however, a form of vertigo which

seems to be literally and directly psychogenic, in that there is no detectable disturbance of vestibular pathways; the symptom presumably originates at the highest brain centers. It is often described merely as a sense of uncertainty, sometimes with mild lurching but no falling and with no nausea; it is absent at complete rest and is unaffected by head movement. Otologic and neurological examinations are negative. Study of the personality structure of the patient and of his attitudes and life stresses may uncover useful evidence of a situation engendering conflict, tension and sometimes depression. The occurrence of vertigo in this setting has been interpreted as a symbolic expression of the patient's own uncertainties and insecurity, and undoubtedly in some instances this explanation is valid.

THERAPY

The treatment of central vertigo begins with management of the underlying disease whenever this is possible. For the symptom itself rest is indicated, plus light sedation. Dramamine in doses of 50 to 100 milligrams three or four times daily as tolerated is often helpful, although the vertigo is seldom completely controlled.

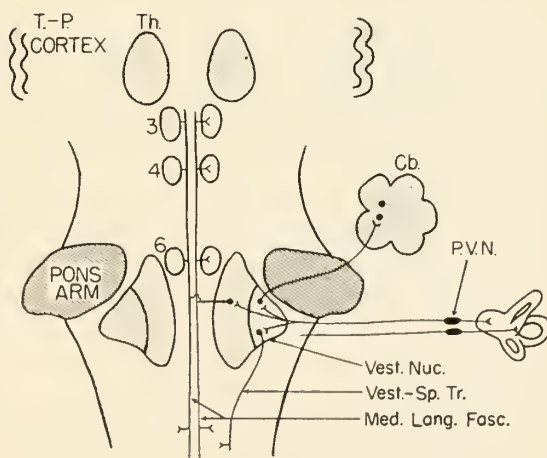


Figure 1. Neural pathways involved in vertigo and associated reactions:—P.V.N.: primary vestibular neurones in Scarpa's ganglion; Vest. Nuc.: vestibular nucleus in pons; Vest.-Sp. Tr.: vestibulospinal tract; Med. Long. Fasc.: medial longitudinal fasciculus; Cb.: cerebellum; Th.: thalamus; T.-P. Cortex: temporo-parietal cortex.

The pons arm (middle cerebellar peduncle) and the nuclei of the 3rd, 4th and 6th cranial nerves are labelled as such.

REFERENCES

1. Denny-Brown, D. E.: Neurologic Aspects of Vertigo, N. E. J. M. 241:144, 1949.
2. Alpers, B. J.: Vertigo: Its Neurological Features, Trans. Am. Acad. Ophth. and Otolaring. 46:38, 1941.
3. Ford, F. R.: Clinical Classification of Vestibular Disorders with Differentiation of Three Syndromes and Discussion of a Common Form of Vertigo Induced by Sudden Movement of the Head, Bull. Johns Hopkins Hosp. 87:299, 1950.
4. Alpers, B. J., and Yaskin, H. E.: The Bruns Syndrome, J. Nerv. & Ment. Dis. 100:115, 1944.
5. Bickerstaff, E. R., and Cloake, P. C. P.: Mesencephalitis and Rhombencephalitis, Brit. Med. J. 2:77, 1951.
6. Davis, D.: A Common Form of Vertigo Relieved by Traction of the Cervical Spine, Ann. Int. Med. 38:778, 1953.
7. Simons, D. J., and Wolff, H. J.: Studies on Headache: Mechanisms of Chronic Post-traumatic Headache, Psychosom. Med. 8:227, 1946.
8. Poston, R. I.: Vestibular or Labyrinthine Epidemic Encephalitis, Brain 49:482, 1926.
9. Dix, M. R., and Hallpike, C. S.: The Pathology, Symptomatology and Diagnosis of Certain Common Disorders of the Vestibular System, Proc. Roy. Soc. Med. 45:341, 1952.

Tinea Capitis

A REPORT OF ONE HUNDRED CASES

ANNE S. ADAMS, M. A.[†] AND KATHLEEN A. RILEY, M. D.[‡]

The following is a summary of a series of one hundred cases of tinea capitis, (ringworm of the scalp) which were seen in the mycology laboratory of the Medical College of South Carolina from the dermatology and pediatric services or in the private practice of one of the authors[‡].

The ages of the patients varied from 9 months to 14 years. Fifty per cent of them were between 4 and 7 years of age. There were 47 white children and 53 Negro children. Seventy-eight per cent were males.

Tinea capitis is caused by fungi in the *Microsporum* and *Trichophyton* genera. *Microsporum audouini* and *Microsporum canis* are the most common. Infections due to *Microsporum gypseum* and to the species of *Trichophyton* are seen occasionally. In the past several years, there has been a marked increase in the number of *Trichophyton tonsurans* infections throughout the United States.^{1, 2, 3} As far as we know, this report carries the first record of *Trichophyton tonsurans* infections in South Carolina.

All of the cases of *Microsporum audouini* infections followed the classical picture of asymptomatic, slowly progressing areas of partial alopecia with broken hairs and scaling. The infected hairs showed a greenish fluorescence under the Wood's light.* None of the patients had secondary bacterial infection.

The cases of *Microsporum canis* infection

followed the same clinical picture as those of *Microsporum audouini* except that lesions caused by *Microsporum canis* usually spread more rapidly. Secondary bacterial infection was seen in only one of the cases due to *Microsporum canis*.

The cases of *Microsporum gypseum* infection presented an entirely different clinical picture from those of the other *Microsporum*s. These lesions, of the classic kerion type, were characterized by the dramatic appearance of an erythematous, elevated, inflammatory mass dotted with pustules and were extremely tender. The surface of the kerions showed partial alopecia and broken hairs which did not show fluorescence under the Wood's light, though they had a dull white appearance.

The cases of *Trichophyton tonsurans* infections, which were completely asymptomatic, showed minimal alopecia with a few broken hairs. The hairs did not fluoresce under the Wood's light but had a dull white appearance.

The one case of *Trichophyton mentagrophytes* infection was clinically indistinguishable from the kerions of *Microsporum gypseum* except that it was not as tender.

The patients described here were a combined series from clinics and a private practice with approximately the same number of patients from each source. Table 1 presents the

[†]Associate in Bacteriology and Mycology, Department of Bacteriology, Medical College of South Carolina.

[‡]Associate Professor of Medicine, Section on Dermatology, Medical College of South Carolina.

*The Wood's light is an ultraviolet light of 3600 angstrom units with a nickle oxide filter. Under this light *Microsporum audouini* and *Microsporum canis* typically produce a greenish fluorescence on infected hairs.

incidence of species of fungi found in this series.

Table 1. Incidence of Species of Fungi in 100 Cases of Tinea Capitis

Causative organism	Number of cases
<i>Microsporium canis</i> -----	39
<i>Microsporium audouini</i> -----	50
<i>Microsporium gypsum</i> -----	5
<i>Trichophyton tonsurans</i> -----	5
<i>Trichophyton mentagrophytes</i> -----	1
Total -----	100

The majority of the private patients were white, and the majority of clinic patients were Negro. This explains the fairly equal distribution of cases in whites and Negroes. Table 2 shows the distribution of etiologic agents between white and Negro patients. Of 39 cases due to *Microsporium canis*, 36 were in white children, while only 3 were in Negro children. Of 50 cases of *Microsporium audouini* infection, 45 were in Negroes and 5 in whites. The remaining 11 cases were caused by *Microsporium gypsum*, *Trichophyton tonsurans*, or *Trichophyton mentagrophytes* and were too few for evaluation of distribution. While it is clear that *Microsporium canis* was seen predominately in the white children and *Microsporium audouini* in the Negro children, we do not feel that this in itself is evidence of racial susceptibility as there are many different environmental factors which might influence incidence of infection.

From the data in table 3, it is apparent that the only significant distribution of the species of fungus as to the sex of the patients was in the case of *Microsporium audouini*. Of 50 cases due to this organism, 45 were in males and five in females. These findings are in agreement with those of other workers.^{4, 5}

SUMMARY

One hundred cases of tinea capitis identified by culture are reported.

The total number of infections according to etiologic agents is as follows: *Microsporium canis*, 39; *Microsporium audouini*, 50; *Microsporium gypsum*, 5; *Trichophyton tonsurans*, 5; and *Trichophyton mentagrophytes*, 1.

The distribution of infectious agents as to race and sex is given. There is a significant difference in the distribution of *Microsporium audouini* infections, 45 of 50 cases occurring in males.

Table 2. Etiologic Agents of Tinea Capitis in White and Negro Patients

	M. canis	M. audouini	M. gypsum	T. tonsurans	T. mentagrophytes	Total
White	36	5	4	2	0	47
Negro	3	45	1	3	1	53
Total						100

Table 3. Etiologic Agents of Tinea Capitis in Males and Females

	M. canis	M. audouini	M. gypsum	T. tonsurans	T. mentagrophytes	Total
Male	20	45	5	4	1	75
Female	19	5	0	1	0	25
Total						100

1. Pipkin, J. L., Arch. Dermat. & Syph. 66:9 (July) 1952, Tinea Capitis in the Adult and Adolescent.
2. Kliguan, A. M. and Constant, E. R., Arch. Dermat. & Syph. 63: 493 (April) 1951, Family Epidemic of Tinea Capitis Due to *Trichophyton Tonsuraus* (variety sulfurum).
3. Howell, J. B. et al., Arch. Dermat. & Syph. 65:194 (Feb.) 1952, Tinea Capitis caused by *Trichophyton Tonsurans*.
4. Swartz, Jacob et al., Arch. Dermat. & Syph. 60:486 (Oct.) 1949, A Survey of Tinea Capitis Including Favus.
5. Lewis, G. M. and Hopper, M. E., Introduction to Medical Mycology. Chicago, The Year Book Publishers Inc., 1948.

Pathological Conference, Medical College of South Carolina

Dr. Arthur William: Mr. Stanley, will you present the protocol for today's conference?

Mr. Stanley: Admission: 27 yr. old white male admitted to Roper Hospital on December 22nd in stuporous state.

History: Essentially well until 1 hour prior to admission, when he had sudden onset of generalized convulsion while lifting some lumber. Quickly became stuporous, confused and incoherent. Wife states that he had had some smothering sensations and slight chest pain for past few days.

Previous Hospital Admissions: Admitted to hospital

in Columbia approximately 1 year previously after having some type of seizure and becoming paralyzed for a short time. Diagnosed as having a nerve injury in his back.

Physical Examination: Fighting and disoriented. BP maintained at 120 systolic with levophed for a while but soon dropped to undetectable level. Pupils equal. Chest apparently clear. Heart sounds distant. Abdomen soft and no organs palpable. Extremities—no paralysis or limitation of motion. Trunk showed numerous blebs—apparently old and filled with clot- ted blood. Wife stated that these had been present

"since he became a man."

Laboratory Data: Lumbar puncture done with patient struggling violently. Fluid apparently under increased pressure, was clear and cell count showed 2 cells—(lymphs.)

Course in Hospital: In Emergency Room he was given sodium amytal gr. 7½-Nasal oxygen started. IV levophed in saline started. Was incontinent. Vomited but no coffee ground material seen. Shortly after LP was done respiration became more shallow and heart action ceased. He was given coramine, artificial respiration and intracardiac adrenalin without effect. Pronounced dead 1 hour after admission.

Dr. Arthur Williams: Mr. Hursey, will you please discuss the case and give your analysis.

Mr. Hursey: This case is essentially a differentiation of the causes of sudden death. The most likely possibilities appear to be as follows: 1. Hemopericardium. 2. Coronary occlusion. 3. Hemorrhage into a silent brain tumor.

Factors supporting the diagnosis of hemopericardium are the shock which persisted and deepened even after the administration of a vasopressor, and distant heart sounds. The convulsion described at the onset was most likely due to cerebral anoxia. Hemopericardium could be the result of rupture of a thoracic aneurysm. Most aneurysms of the thoracic aorta are syphilitic. However, the absence of positive physical findings one year ago and the patient's age make such a diagnosis less likely.

Dissecting aneurysms also occur in the thoracic aorta. Such an aneurysm could occur in a 27 year old white male without previous evidence of cardiovascular disease and rupture into the pericardial sac. Such a process is usually preceded by intense agonizing pain in the precordium and extending to the jaw, neck, flank or extremities. The convulsions which are described may have been manifestations of his pain.

Dr. Williams: What is the cause of dissecting aneurysm?

Mr. Hursey: Atherosclerosis is possibly related to some cases, medionecrosis of the aorta and perhaps syphilis.

Dr. Williams: What is the histological picture of syphilitic aortitis?

Mr. Hursey: Syphilis of the aorta is primarily medial disease with inflammation and fibrous scarring.

Dr. Williams: Could such a process give rise to dissecting aneurysm?

Mr. Hursey: I believe it may.

Dr. Williams: Please, continue.

Mr. Hursey: Hemopericardium could also result from spontaneous rupture of the aorta. In this instance there would be sudden agonizing pain in the precordium with severe shock or prostration and more distant sounds. The mechanism is the same as in dissecting aneurysm but instead of the process dissecting along the media there is a transverse tearing through the entire thickness of the aorta.

Another cause of hemopericardium is rupture of the heart at the site of a preexisting but unsuspected myo-

cardial infarction. With increased cardiac activity due to the physical exertion of lifting, an area of weakened myocardium may give way with bleeding into the pericardial sac.

Statistically the commonest cause of sudden death is coronary occlusion. However, the apparent convulsion with stupor and confusion cannot be explained.

Least likely but still a possibility is a brain tumor in a silent area. Due to necrosis of vessel walls hemorrhage occurs into the tumor with resulting stupor and coma. It is unlikely for this to occur without evidence of localizing signs.

My first choice, however, is dissecting aneurysm with rupture into the pericardial sac.

Dr. Williams: Mr. Levi, what would you think of in a patient with a history of convulsions and in a stuporous condition?

Mr. Levi: In a 27 year old male in good health until a few hours before admission and with no previous history of epileptiform seizures I would consider a cerebro-vascular accident. The cause is usually rupture of a congenital or "Berry" aneurysm of the Circle of Willis. Although this gives rise to subarachnoid hemorrhage and thus a bloody spinal fluid, on occasion clear fluid has been obtained. This would be possible if the aneurysm were situated within the substance of the brain rather in the Circle of Willis specifically.

Intracerebral hemorrhage also may occur into an anaplastic brain tumor but the absence of localizing signs makes this unlikely.

Other considerations include disorders of cardiac rhythm with cardiac standstill. However, death if it occurs is immediate rather than after 2-3 hrs.

Patients with aortic stenosis also will die suddenly. This is usually a result of acute coronary insufficiency. In this case there is no indication on the protocol to suggest stenosis.

Dr. Williams: Is there any process involving the mitral valve which might result in sudden death?

Mr. Levi: A patient with mitral stenosis and auricular fibrillation frequently will have thrombi within the auricular appendage. An embolus to the brain could develop from such a source and cause sudden death. The lack of history or physical findings to establish a diagnosis of mitral stenosis and absence of localizing signs tend to exclude this possibility.

Dr. Williams: Would you consider meningococcemia as a cause of death?

Mr. Levi: I see nothing to support such a diagnosis. The skin lesions although suggestive are less significant in view of the history. Also there is no evidence of a febrile course which should be present.

Dr. Williams: Do you relate the terminal event to the hospitalization of one year ago?

Mr. Levi: I can see no relation.

Dr. Williams: Do you believe the pathologists are giving you a "red herring" and attempting to deceive you?

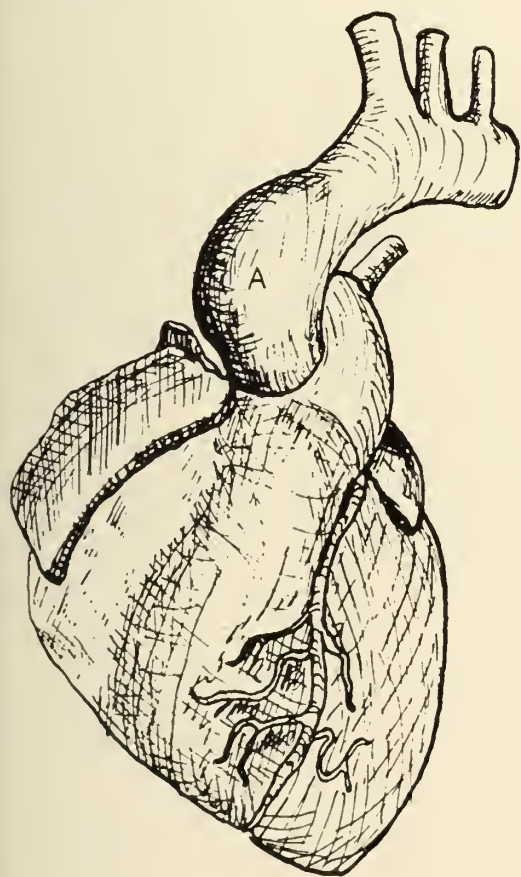
Mr. Levi: That is possible.

Dr. Williams: Do you believe the pain is consistent with a diagnosis of dissecting aneurysm?

Mr. Levi: The pain of dissecting aneurysm is typically severe, unrelenting and agonizing. This man had no such pain according to his wife. Perhaps dissection occurred slowly rather than sudden extensive splitting of the media. Actually the pain is more consistent with coronary artery disease. It is unusual, though, for a young man without history of previous cardiac disturbance to succumb to an initial infarction unless complicated by cardiac rupture and tamponade. This would be more apt to occur several days after the infarction.

Dr. Williams: Where would you expect rupture of a dissecting aneurysm to occur?

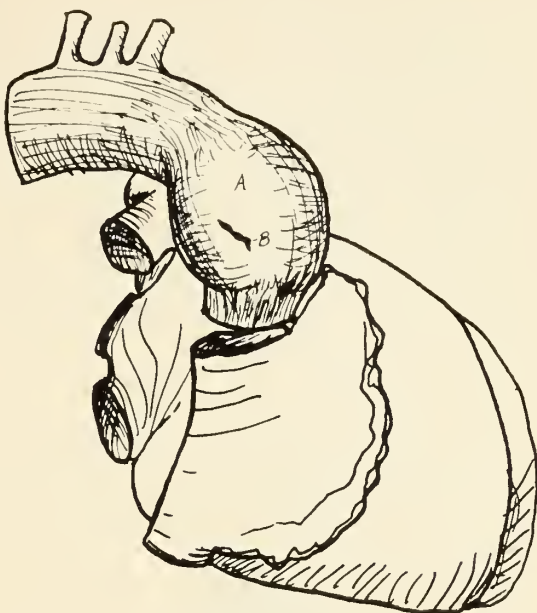
Mr. Levi: A dissecting aneurysm may rupture through the adventitia at any point along the course of the aorta. The most frequent sites are into the pericardial sac, pleural spaces, retroperitoneal tissues



ANTERIOR

Figure 1. Heart showing anterior surface as viewed in situ.

A—Aneurysmal bulge.



RIGHT LATERAL

Figure 2. Heart rotated to expose rt. lateral surface. A—Aneurysm. B—Site of rupture.

or abdominal cavity. In the absence of abnormal lung findings and the notation that heart sounds were diminished it would appear in this case that rupture occurred into the pericardial cavity.

Dr. Williams: This is your first choice of diagnosis?

Mr. Levi: Yes sir, although I am unable to exclude the possibility of myocardial infarction.

Dr. Williams: Mr. Rawl, what is your opinion of this case?

Mr. Rawl: Statistically myocardial infarction is the commonest cause of sudden death but dissecting aneurysm cannot be excluded.

Dr. Williams: What is the typical pain of dissecting aneurysm?

Mr. Rawl: Pain is characteristically persistent and severe. In this case the pain is more like that of coronary insufficiency with the development of myocardial infarction as the cause of death.

Dr. Williams: Can neurological signs of a convulsion one year ago be related to the present illness which manifested itself by a convulsion.

Mr. Rawl: Yes, a brain tumor may have been present all the time but located in a silent area. Sudden hemorrhage into a cerebellar tumor particularly may produce sudden death.

Dr. Williams: How would you treat this patient as first seen in the emergency room in severe shock.

Mr. Rawl: First determine the type of shock. Distinguish between neurogenic shock, shock due to acute blood loss and shock related to a failure in the pumping mechanism. I think the treatment of choice

would be a vasopressor such as levophed which was used in this case.

Dr. Williams: What kind of shock do you get in myocardial infarction?

Mr. Rawl: There would be a combination of neurogenic shock and failure of the heart.

Dr. Williams: Do you mean forward failure?

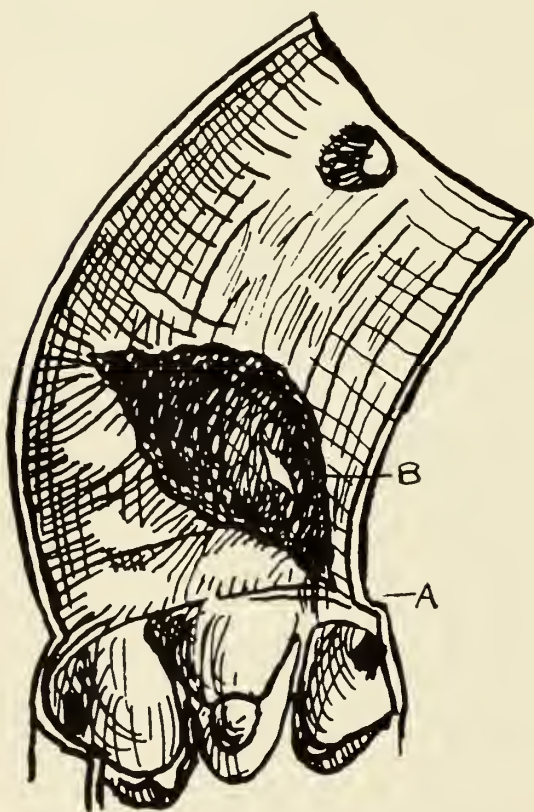
Mr. Rawl: Yes sir.

Dr. Williams: How would you distinguish between forward failure and neurogenic shock?

Mr. Rawl: Cardiac failure would be apparent by evidence of increase in venous pressure such as the presence of moist rales in the lungs and perhaps distension of the neck veins.

Dr. Williams: What is your first choice as to diagnosis?

Mr. Rawl: Myocardial infarction is my first choice but I'm unable to exclude the possibility of either hemorrhage into a brain tumor or a dissecting aneurysm.



AORTA

Figure 3. Aorta when opened to show intimal surface.

A—Aortic ring. B—Intimal tear.

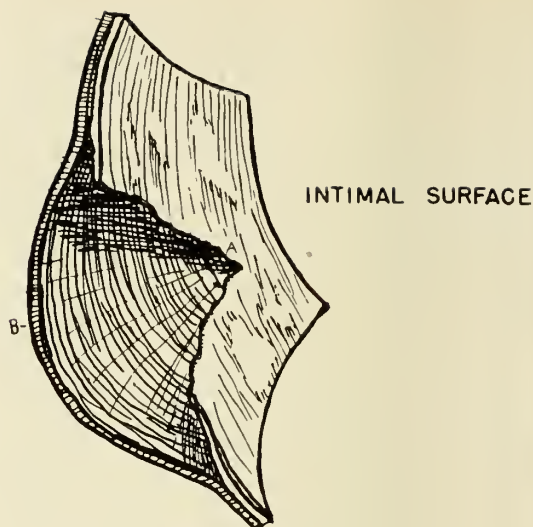


DIAGRAM OF RENT IN INTIMA

Figure 4. Aorta showing longitudinal section through aneurysm.

A—Intimal tear. B—Aneurysm.

Dr. Edw. E. McKee: This patient died as a result of rupture of a small dissecting aneurysm of the aorta with hemorrhage into the pericardial sac.

The pericardial sac contained 500 cc of blood and there was a 1 cm. defect in the wall of a 4 cm. dilatation at the base of the aorta (Figs. 1 & 2). As the heart and aorta were opened this dilatation was found to be related to a 6 cm. tear in the intima of the aorta, (Figs. 3 & 4). This tear began at the level of the aortic ring and extended diagonally upward to a point 3 cm. above the level of the ring. The entire aneurysmal dilatation is within the pericardial cavity.

The microscopic examination of the aorta shows minimal atherosclerosis. In the media the musculo-elastic fibers are irregularly frayed with interspersed pools of mucoid-like material. Elastic tissue stains demonstrate more clearly this fragmenting of the musculo-elastic fibers. This is the process named idiopathic medionecrosis, the etiology of which is unknown although it is most likely a degenerative change resulting from some circulating toxin.

This alteration of the media unfortunately may exist unrecognized until it results in dissection of the aorta with rupture and death or in spontaneous rupture of the aorta.

Dr. Williams: Is there any evidence of syphilis? Is syphilis a cause of dissecting aneurysm?

Dr. McKee: There is no histological evidence of syphilis. Insofar as we know there is no relationship between syphilis and the development of a dissecting aneurysm. In an occasional hypertensive with severe atherosclerosis, dissection may begin at the site of an ulcerated atheromatous plaque.

The pathogenesis of dissecting aneurysm is almost always related to the presence of idiopathic medionecrosis. This to varying degrees weakens the vasa vasorum and in the presence of hypertension even of transitory nature there may be rupture of these small vessels with hemorrhage into the media. The force of the hemorrhage may split or dissect the media, limited by the extent of medial involvement, or break through the adventitia with fatal hemorrhage. There may be one or more intimal tears related to the process or possibly none. If there is an intimal tear the commonest site is above the aortic ring or at the site of the ligamentum arteriosum for at these points the

vessel is relatively immobile and subjected to the greatest pressures.

Dr. Williams: Do you in any way relate the terminal episode to the complaints of a year ago?

Dr. McKee: The gross demonstration of a bulge in the aorta suggests that there may have been dissection at an earlier date than 2-3 hrs. or a couple of days. This may have coincided with the complaints of a year ago but we cannot date it specifically. With an existing small aneurysm, further damage occurring recently then results in death.

(The illustrations were prepared by Dr. M. F. Patton.)

"A FAMILY DOCTOR FOR EVERY DOCTOR'S FAMILY." The American Academy of General Practice is enlisting the support of the American Medical Association and other medical organizations in a project which is being given high priority support during 1954. The project is best described by the slogan, "A Family Doctor For Every Doctor's Family."

The academy undertook the project because it felt that, like the cobbler's children who have no shoes, the doctor's family may be getting the poorest medical care and attention.

The idea first was formulated by Dr. Merrill Shaw, academy vice-president, who has been critically ill at his home in Seattle.

In outlining the idea to the academy's board of directors, Dr. Shaw said he was convinced that physicians and their families receive "hopscotch" medical attention, neglect their own health, and seldom have a thorough check-up. He said that during his 20 years as a general practitioner, he does not recall that a single doctor ever came to him for a physical examination.

The impression seems to have grown among physicians that nutrition is less important in practice of medicine than it appeared a few years ago. Nothing could be farther from the truth. Nutrition has a much greater place in medical practice than ever before. It is true that the incidence of certain vitamin deficiencies is probably less. It is true that the diet generally is better. It is also true that the public consumes, in one way or another, a tremendous quantity of vitamins. But two facts establish the greater role of nutrition in practice. First, the fact that doctors are concerned not only with idiopathic, primary nutritional deficiency, but with a great mass of conditioned deficiency, deficiency resulting from some disease or injury which has made for

conditions under which nutritional deficiency can develop. And second, the fact that as our knowledge of nutrition expands, we find constantly increasing relationships between nutrition and various diseases, injuries and states of ill health.

John B. Youmans

Medical Schools' Responsibility for Continuation Education

Although other medical organizations could participate, it is primarily the duty of the medical school to provide opportunities for continuation medical education for physicians, according to Dr. Walter S. Wiggins in an article appearing in the May issue of *The Journal of Medical Education*.

A medical school, states Dr. Wiggins, should be judged on the quality of medicine practiced by its graduates throughout their lifetimes, instead of on their ability at the time of graduation. Since this is the case, the medical school should assume responsibility for keeping physicians up to date, stimulating hospitals to provide additional services for good quality medical care and for the education of ancillary personnel.

Dr. Wiggins criticizes the practice of relying too much on longer and more frequent lectures as the stream of medical knowledge grows wider. He feels that a sounder way to inspire interest in continuation medical education would be "to bring together the student, the patient and the teacher; or the student, the teacher and the laboratory, and be less concerned with counting the slumbering heads of registrants at our continuation courses."

Dr. Wiggins suggests, "We should utilize facts in teaching so that concepts may be learned and hope that the concepts are what remains after the facts that have been taught are forgotten."

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain Mullins
J. D. Guess Greenville
C. J. Milling Columbia
H. R. Pratt-Thomas Charleston

Vince Moseley Charleston
Ben Miller Columbia
W. H. Prioleau Charleston

G. D. Johnson Spartanburg
R. M. Pollitzer Greenville
Hugh Smith Greenville
Walter Mead Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Charleston, S. C.

Subscription Price

\$3.00 a Year

JUNE, 1954

The Southern Pediatric Seminar

Thirty four years of successful teaching will be achieved this year by the Southern Pediatric Seminar, now expanded to include obstetrics, gynecology, and internal medicine.

Originated many years ago by Dr. Lesesne Smith and a group of interested medical friends, this seminar has furnished an opportunity for brief postgraduate courses given by some of the outstanding men of the South, both professional teachers and experienced practitioners, and has provided the combination of study and vacation in a stimulating mountain atmosphere.

The addition of a week of obstetrical and gynecological lectures and discussions has proved so successful that a new venture in the field of internal medicine is being added in the form of a two-day session to be conducted by Dr. Hugh Hussey and his associates.

The Seminar begins on July 12. No doubt, this year will provide as stimulating teaching as have the years past. It is a unique institution and a remarkably easy way of obtaining sound postgraduate instruction.

The Annual Meeting

An unusually interesting and interested meeting was held at Myrtle Beach early in May. There was an excellent attendance, much business activity, a good scientific program, and an ample supply of events of a social nature. The whole procedure ran smoothly and agreeably. There were no major conflicts of opinion, and the affairs of the Association were cared for in an expeditious manner.

There was a good display of commercial exhibits. These are the financial underpinnings of the meeting, and a deserved attention was

given them by the assembly. For the efficient overall management the Association is indebted to our executive secretary, Mr. M. L. Meadors. Minutes of the meeting will appear soon in this Journal.

For next year an invitation has been accepted for a meeting in Charleston. It is expected that the Medical College Hospital will be opened at that time, and that our members will be introduced to the building and to the workings of this new and imposing institution.

Dr. Julian Price Commended

The April issue of the Medical Annals of the District of Columbia carries an editorial very laudatory of Dr. Price as a physician, and especially, of Dr. Price as a successful extemporaneous speaker. The occasion for the editorial was an unexpected address to a group of medical students, to whom Dr. Price expounded forcefully the six qualities of a proper physician—viz. good training, awareness of current advances, a healthy medical skepticism, a primary concern for the patient, a sound moral character, and an active participation in community affairs. The passage closes with the remark that Dr. Price's "career in medicine is a vital example of what a physician should be."

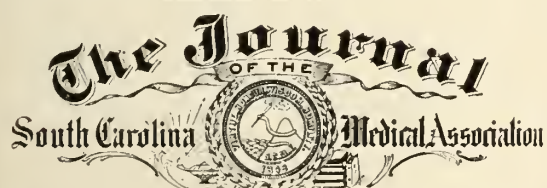
The Tennessee Plan

Of the many plans proposed for solving the problem of veterans' medical benefits, the plan which is to be offered by the Tennessee committee for consideration by the AMA seems to run completely away from all the various modifications previously proposed.

Some years ago Dr. H. H. Shoulders of Tennessee, a former president of the AMA,

offered a proposal that the federal government take care of medical and hospital insurance for all veterans "unable to pay," regardless of the type of disability or its connection with the veterans service. After an unsuccessful effort, the same plan from the same source, is to be offered for adoption. This attempt is opposed most vigorously by the Association of American Physicians and Surgeons, which goes even beyond the present stand of the AMA in that it wishes to eliminate the present broad benefits for care of tuberculous and mental cases, and to discourage the building of more hospitals for veterans.

This matter will receive consideration at the June meeting of the AMA. If we understand the plan correctly, we suggest that it be presented with an accompaniment by the old song "There's a rainbow 'round my Shoulders, and the skies are blue above."



Forty Years Ago

JUNE 1914

Pickens County Medical Society held a clinical meeting at Central, using the school building for demonstrating cases . . . The Association had 704 members . . . A. M. A. representatives were organizing or reorganizing county societies . . . Annual income of the State Association was \$1715.52 . . . Increase in small-pox was reported . . . One county of the state had a full time health officer . . . Dr. W. A. Smith read a paper on "Aneurysm of the Sinus of Valsalva." In Sumter, Dr. Carl B. Epps read a paper on "Tetanus, treated successfully with antitoxin." Dr. C. J. Lemmon, with due modesty, was reported to have discussed the inheritance of "a certain very much dreaded disease."

THE PRESIDENT-ELECT

Dr. Orlando Benedict Mayer, III was born on July 29, 1897, in Newberry, S. C., the son of Dr. & Mrs. O. B. Mayer, Jr. He attended the public schools there and later graduated from Newberry College, receiving his A. B. degree in 1917, and then entered the Medical College of South Carolina as his grandfather and



father had done. After finishing the second year there, he transferred to Western Reserve Medical School and received his M. D. degree in 1921. He then interned at Lakeside Hospital, Cleveland, Ohio, completed his medical residency in 1924, and that year received his M. A. in medicine from Western Reserve School of Medicine. Then he located in Columbia, for the practice of Internal Medicine. In 1926 he further pursued his medical studies by taking courses in Vienna, London, and other European clinics. In 1934 he became a diplomate of the American Board of Internal Medicine.

He is a member of the Kappa Sigma and Alpha Kappa Kappa Fraternities, and a member of Forest Lake Club and the Cotillion Club. He belongs to the American Medical Association, American College of Physicians, and the Southern Medical Association, and is currently a Medical Consultant to the Army Hospital at Fort Jackson.

In 1935 he married Nancy Phillips. They have three daughters—Nancy Phillips, age 15, Cornelia Flemming, age 13, and Ella Reese, age 8.

In 1941 he entered military service becoming Chief of Medicine at the Station Hospital, Fort Jackson, and later was transferred to Barnes General Hospital, Vancouver, Washington, as Chief of Medicine where he remained until discharge from active duty in 1946 with the rank of Colonel. He then resumed his private practice in Columbia.

He is a past president of the Columbia Medical Society and the Medical Club. In 1946 he was elected Councilor for the Second District, and in 1947 was elected chairman, which position he occupied until 1951.

CAT.



AND
A FORMER PRESIDENT
DR. O. B. MAYER, JR.
1854-1918

Dr. O. B. Mayer, Jr., son of Dr. O. B. Mayer was born August 23, 1854 in Newberry, South Carolina. Like his father before him he subsequently entered the Medical College in Charleston and graduated in 1874 at the age of 20 with second honor, completing the customary two years course. After his graduation he entered private practice with his father in Newberry, South Carolina, but later left his father to practice alone. It was his habit in later years to supplement his medical training with post graduate courses in New York. He was a trustee and professor of Physiology and Hygiene in Newberry College and lectured there for many years. In 1874 he was a member of the South Carolina Medical Association, then a struggling society with only 150 members. He took a very active part in this organization and was honored with the Presidency in 1886. In his inaugural address he urged attendance at medical meetings for the exchange of medical knowledge and experiences, and throughout the years he lived this doctrine and urged organized medicine to further the growth and scientific progress of medicine. He was a member of the State Board of Medical Examiners from 1889 to 1907 as examiner for the subjects of obstetrics and gynecology. For many years he was Chairman of the Board of Councilors of the Medical Association, and in this capacity delivered many addresses throughout the state on health problems: anti-tuberculosis, development of parks, etc., and in addressing women's clubs discussed food problems, cleanliness and cheerfulness in the home because

he believed in the home as a cheerful refuge after a day's work. He enjoyed a large general practice and was frequently called as a consultant in a wide adjacent territory. The necessity for proper nursing was evident to him and he imported from New York the first graduate nurse in the community. He was among the first in the state to treat diphtheria with antitoxin. In 1894 Newberry College conferred upon him the degree of Master of Arts. By 1912 his health had begun to fail, and he retired from all except office and consultation work. On June 13, 1918 he died at the age of 64 years.

BOOK REVIEW

CHILDREN FOR THE CHILDLESS: Edited by Morris Fishbein, M. D. New York, 1954, Doubleday & Company, Inc. 223 pages with 10 figures and a bibliography for the general reader. \$2.95

This book is described as a "handbook for the single and married and a source of hope for the childless." Eight authors, including such well-known workers as Nicholas J. Eastman, I. C. Rubin, and J. P. Greenhill, have each contributed a chapter. These are further divided into pertinent sections, thus comprising a kind of omnibus of the various facets of fertility and sterility. Portions of the book either are worded so scientifically or else are so detailed that they are more suitable for the student than for the average patient. However, the chapters on being a parent today, physical aspects of fertility and sterility, artificial insemination, and adoption, are quite appropriately written for the laymen and offer much practical information.

J. Richard Sosnowski, M. D.

Minutes of Council Meeting Myrtle Beach, S. C., May 10, 1954

This first meeting of Council in conjunction with the Annual Meeting of the South Carolina Medical Association was held at the Ocean Forest Hotel, Myrtle Beach, S. C. at 3 p. m. The meeting was called to order by the Chairman, Dr. O. B. Mayer; members present were Drs. Baker, Morgan, Bozard, Gaines, Guess, Gressette, Wilson, Cain, Smith, Wyatt, Weston, Stokes, Johnson, Waring, Crawford and Mr. M. L. Meadors.

The minutes of the special meeting of Council of September 23, 1953 were read and confirmed.

The Chairman first recognized Dr. Roderick McDonald, Chairman of the Grievance Committee, who reported on the various cases coming to the attention of his committee during the past year. Dr. McDonald then presented a complaint from Anderson County in regard to the misuse of narcotic and barbiturate prescription and asked the advice of Council as to what procedure should be followed by his Committee. Dr. Gaines reported some conversations in this matter and Dr. Wyatt suggested that the State Inspector be asked to investigate it. After discussion by Drs. Baker, Weston, Cain and Stokes, Dr. Weston moved that a committee of three be appointed to investigate, consisting of the President of the Anderson County Medical Society, Dr. Wyatt as Councilor from this district, and Dr. Goldsmith as a member of the Committee from this district. After some further discussion the motion was lost. Dr. Smith then moved that the Grievance Committee be directed to proceed with this matter and be given authority to reach any

decision that they may see fit. This motion was carried.

Dr. Morgan reported that he had received a request from Dr. Whitten of the Clinton hospital citing the need for medical assistance in his institution and their policy of employing displaced persons as physicians. The Chairman read a letter from Dr. W. S. Hall, Superintendent of the State Hospital, in regard to the use of such physicians in a professional capacity at the State Hospital as well. Dr. Johnson first moved that Council approve of this procedure but Dr. Gaines recommended no action and presented a substitute motion to the effect that while Council cannot give official approval to this because of previous action of the House of Delegates it is sympathetic to the procedure being followed. After some discussion this motion was passed and the Secretary directed to write to Drs. Whitten and Hall to this effect.

A letter from Dr. T. G. Goldsmith was presented, asking Council to approve the essay contest in high schools for the coming year and a motion to this effect was passed, with the further stipulation that the amounts of the prizes remain the same as they have been in the past.

A letter suggesting subscriptions to the "Challenge to Socialism" was presented and Dr. Wyatt moved that the Executive Secretary, be authorized to enter subscriptions to this publication for the President, Secretary, and the Executive Secretary; a motion to this effect was passed.

The Secretary reported that the office of the Secretary of the AMA showed there were 1149 members of the S. C. Medical Association enrolled as active members of the AMA, entitling this Association to 2 delegates. A letter of resignation from Dr. J. D. Guess as Delegate was read and accepted with regret; it was suggested that a successor to Dr. Julian Price be elected for a term ending January 1, 1955 and that another Delegate be elected for a two year term, January 1, 1955 to January 1, 1957, so that the terms of the two Delegates from the Association would be staggered, one to be elected each year. A motion to this effect was passed.

The Secretary further reported his attendance at the Regional Legislative Conference of the AMA held in Atlanta, January 31, 1954. Letters in regard to the Bricker Amendment from the two Senators from South Carolina were read. The Secretary reported that the S. C. Obstetrical and Gynecological Society had nominated Dr. Frank Geibel of Columbia, S. C. as Chairman of the state committee on Maternal Welfare. Various resolutions from the state of Iowa in regard to principles of medical ethics were noted and received as information. The Secretary reported the formation of the chapter of the student American Medical Association at the Medical College of S. C. and requested the appointment of one member from the State Association on the Board of Advisors of this student organization; the Council directed that the Secretary, Dr. Wilson, assume this post.

The Secretary presented resolutions passed by the

Association of American Physicians and Surgeons as being unequivocally opposed to H.R-6863 and H.R-7199 (Compulsory inclusion of physicians in Social Security) and Council passed a motion that this be approved and the House of Delegates be asked to likewise give its approval. Council then approved the passage of the Keogh-Read Bill, and suggested similar presentation to the House of Delegates for consideration.

Dr. William Weston then moved that the name of the Grievance Committee be changed to Mediation Committee, to conform with the policy of the American Medical Association, and this was likewise passed.

The Executive Secretary suggested that hereafter drawing for prizes be held after the Scientific Session and not at the Banquet and a motion to carry this into effect was passed. He also moved that the present contract with the Veterans Administration, with the existing fee schedule, be approved for renewal and this was passed.

No formal reports were received from the President, Vice-President or President-Elect. The Executive Secretary, Mr. Meadors, presented a formal report that he was to present to the House of Delegates and this was given the approval of Council. Council likewise approved the report of the Treasurer and of the Secretary. The Editor reported on his few months in office and suggested that special issues of the Journal to honor the opening of the Medical College Hospital next year, and to signalize the 50th anniversary of the establishment of the Journal be authorized. A motion to approve this was passed, with the proviso that the additional cost was not to exceed \$200 each.

Dr. Weston gave his report as Delegate to the AMA which he was to present to the House of Delegates the next day and Dr. O. B. Mayer, Chairman of Council, likewise gave his formal report. Both of these reports were approved.

Dr. Bozard commented on the lack of adequate publicity both before and during the meetings of the State Medical Association and this occasioned considerable discussion. Dr. J. D. Guess, President of the Board of Directors of the S. C. Medical Care Plan, presented his report to Council and requested passage of the following resolutions:

(1) Resolved that the Council of the S. C. Medical Association, in meeting assembled May 10, 1954, approve all actions and regulations pertaining to the eligibility of groups to become subscribers to the S. C. Medical Care Plan and those pertaining to the method of processing physicians claims and the schedule of physicians allowances, which have been put in effect by the Board of Directors of the S. C. Medical Care Plan.

(2) To change article IV, Section 3 of the By-Laws of the S. C. Medical Care Plan so that it would read: "All rules and regulations relating to the determination of income groups eligible to become subscribers and all changes in the schedule of allowances to physicians, including their interpretation and regulatory provisions, shall be subject to review at all times by

the Council of the South Carolina Medical Association in an advisory capacity."

On motion of Dr. Wyatt, seconded by Dr. Smith, both of these regulations were approved.

Dr. Guess then nominated the following to serve on the Board of Directors of the S. C. Medical Care Plan, whose names would be presented to the House of Delegates for election: Drs. Stokes, Baker, Goldsmith, Brabham, and Mr. Gilhooly. Council approved the nomination of these for presentation to the House of Delegates.

Dr. D. L. Smith suggested that Dr. Julian Price, Trustee of the AMA, be invited to attend meetings of Council and Dr. Cain then presented a motion to the effect that any high official or Trustee of the AMA be an Ex-Officio member of the Council in an advisory capacity during the term of his office. A motion to this effect was passed.

Dr. Cain then commented on the entertainment arranged by the Alumni Association at the Annual Meeting.

The following nominations were then made for presentation to the House of Delegates. Treasurer—Dr. J. H. Stokes; Members of the Mediation Committee—First District—Drs. J. A. Siegling and Norman Walsh; Fourth District—Drs. T. C. Goldsmith and A. C. Bradham; Seventh District—Drs. N. O. Eaddy and T. M. Davis.

Mr. M. L. Meadors, Executive Secretary then presented resolutions regarding the practice of Naturopathy which had been adopted by the Pee Dee Medical Association and other County Societies, and on motion of Dr. Wyatt this was approved with instructions to the Executive Secretary to write the county societies of this action. Mr. Meadors then brought up the question as to the advisability of political action during the present year and after some discussion it was moved that the Councilors of each District be instructed to write to the Secretaries of each medical society in their jurisdiction requesting that uniform questions to all candidates be asked so that their stand in regard to Naturopathy might be publicized. A motion to this effect was passed.

Council then adjourned at 7:05 p. m.

Respectfully submitted,

Robert Wilson, M. D.

Secretary

Minutes of Council Meeting Myrtle Beach, S. C., May 11, 1954

Council reconvened at 9:30 a. m. and was called to order by the Chairman, Dr. O. B. Mayer. Members present were Drs. Wyatt, Baker, Morgan, Guess, Weston, Smith, Bozard, Stokes, Johnson, Gaines, Gressette, Cain, Wilson, Waring and Mr. M. L. Meadors. The death of the father of Dr. Julian Price was announced by the Chairman and the Secretary was directed to send a telegram of sympathy to Dr. Price. Dr. J. Howard Stokes took up a contribution by the individual members of Council and he was directed to use this for some memorial to Dr. Price's father.

Dr. Gaines spoke of the space reserved for the Woman's Auxiliary and recommended that Council grant such space each year. A motion to this effect was passed.

Dr. Weston announced to Council that a resolution regarding the sale of lye was to be made to the House of Delegates at its meeting.

Dr. Cain spoke on the question of publicity, the release of press reports and the hiring of some Public Relations Expert and Dr. Weston recounted the policy of the AMA in this regard. After some discussion by Drs. Wilson, Waring, Wyatt and Cain, Dr. Weston moved that Council appoint a director of publicity to take care of releases to the press at the time of the Annual Meeting and at other times, who would be someone in the newspaper and advertising business. This motion was tabled and a substitute motion was presented by Dr. Cain, that the Chairman appoint a committee of three to investigate the possibility of engaging the services of a Director of Publicity and that the reference committee of the House of Delegates be informed of this action. This motion was passed. Dr. Mayer announced that the present Publicity Committee consisted of the Executive Secretary, the Editor, and the Secretary of the Association and these would be in charge of publicity at the present meeting.

Dr. Mayer, Chairman of Council, then read a supplementary report which was approved by Council. The meeting was then adjourned.

Respectfully submitted,

Robert Wilson, M. D.

Secretary

Minutes of Council Meeting Myrtle Beach, S. C., May 12, 1954

Council reconvened at 9:00 a. m., called to order by the Chairman, Dr. O. B. Mayer. Members present were Drs. Baker, Stokes, Guess, Wilson, Gaines, Morgan, Bozard, Smith, Wyatt, Gressette, Cain, Johnson, Weston, Waring and Mr. M. L. Meadors. The members of a Committee from the Women's Auxiliary were introduced and reported to Council. Mrs. David A. Wilson, President, and Mrs. A. T. Moore, President-Elect, reported on the various activities of their organization, and Mrs. J. Workman presented the treasurer's report. These were received as information and the ladies thanked for their efforts in this regard.

Dr. Bozard then moved that the present publicity committee consisting of the Executive Secretary, the Editor, and the Secretary, be authorized to investigate the employment of some person as a publicity representative, to prepare and secure publications of news and press releases of interest to the public and to the medical profession, and that Council be authorized to employ such a person at a salary of not more than \$100 a month. After some discussion a motion to this effect was passed.

Dr. Davis of Sumter then presented his findings in regard to the possibility of the Association choosing a cruise for one of its subsequent annual meetings and

this was received as information.

Council recessed and the new Council, just elected by the House of Delegates, reconvened at 12:30 p. m. May 12, 1954. Members present were Drs. Mayer, Baker, Cain, Wyatt, Gaines, Gressette, Burnside, Stokes, Waring, Bozard, Crawford, Morgan and Wilson. Dr. Joseph Cain of Mullins, S. C. was elected Chairman of the Council. Other officers elected this time were as follows: Dr. Charles Wyatt, Vice-Chairman; Dr. A. Bozard, Clerk; Dr. Robert Wilson, Secretary Ex-Officio. Council then adjourned for the day.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

**Minutes of Council Meeting
Myrtle Beach, S. C., May 13, 1954**

Council reconvened at 5:30 p. m. and was called to order by the Chairman, Dr. J. P. Cain. Members present were Drs. Gaines, D. L. Smith, Wilson, Wyatt, Weston, Waring, Morgan, Crawford, Bozard, Bachman Smith, Mayer, Johnson, Stokes and Mr. M. L. Meadors.

Mr. M. L. Meadors was re-elected Executive Secretary with a salary fixed at the same level as during the present year. Dr. J. I. Waring of Charleston was elected Editor of the Journal for the coming year. On motion of the Secretary, the Treasurer was authorized to pay the bill for the gift to be given to the retiring President, Dr. C. R. F. Baker.

The following budgets were then presented and approved.

<i>Secretary</i>	
Office help	\$ 900.00
Office expense, supplies, tel. and tel.	600.00
Travel	500.00
Total	\$ 2,000.00
<i>Editor</i>	
Salary	\$ 1,200.00
Office help and expense	600.00
	\$ 1,800.00
<i>Executive Secretary (Including Treasurer)</i>	
Salary	\$ 7,200.00
Office help	6,500.00
Office Assistant (previously for Editor)	900.00

Travel	1,500.00
Office rent	600.00
Office supplies	750.00
Tel. and Tel.	500.00
Heat, lights, water	150.00
Conferences and other Public Relations Act.	500.00
Bond Premium	155.00
Total	\$18,755.00

The Woman's Auxiliary \$.50 per member (all paying members)	\$ 600.00
General Contingent Fund	\$ 1,000.00

On motion of the Secretary, Council approved the authority for the second alternate to the AMA be sent to one meeting of the AMA at the expense of the Association and this was passed.

There was some discussion as to the expenses of officers of the Association and Dr. Mayer moved that the Chairman of Council appoint a committee of three to study the finances of the Association in regard to the expenses of officers and to report at the next meeting of Council with recommendations. Dr. Johnson suggested that the policies of Council in this regard be incorporated in the report of the committee as noted above and with the inclusion of this amendment, the original motion was carried.

On motion of the Secretary the previous policies in making every effort for the Scientific program of the Annual Session to be distributed at least one month prior to the time of the meeting, and to include the names of all delegates to the House, and that the County Societies be requested to elect their Delegates and Alternates so that their names might be in the hands of the Program Committee by not later than February 1st were approved as the permanent policy of the Association.

It was moved by Dr. William Weston, Jr. that the Annual meeting for 1955 be set for the first or second week in May but this motion was tabled and after some discussion a motion carried that the date be settled among a committee consisting of the Chairman of Council, the President of the Medical Association, the President of the Medical College, the Executive Secretary, and the Secretary, at a time fitting to all concerned.

Council then adjourned sine die, to reconvene at the call of the Chairman.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

Committee Reports

**REPORT OF THE EXECUTIVE COMMITTEE
OF THE STATE BOARD OF HEALTH
TO THE SOUTH CAROLINA MEDICAL
ASSOCIATION 1954**

Safeguarding the health of South Carolina is always a big job. If epidemics strike or certain diseases are

on the increase, the task is well defined. Often the best work is done in a less tangible or spectacular way.

In the interim between the last annual meeting of our Association and one assembled today, a great deal has been done to build up barrier against disease and

to strengthen our first line of defense.

One year ago we were thinking about the effects on polio of Gamma Globulin if properly distributed and used. Fortunately we have not been called upon to make an extensive use of this agent but where polio was found, the household contacts below 30 years of age were given adequate doses. We believe the results in this State have been encouraging but the number is too limited to draw conclusions. The accumulated evidence of the whole country seems to show that it is not a worthwhile procedure.

At this time the focus is on the vaccine developed by Dr. Jonas Salk working in Pittsburgh.

In view of the great interest and amount of publicity given this vaccine, the South Carolina State Board of Health is desirous that the true nature of the proposed field trials be thoroughly understood. It must first be emphasized that as yet there is no scientific proof that the vaccine will prevent poliomyelitis in humans. The vaccine has shown evidence that it does prevent poliomyelitis in experimental animals, and in volunteer human subjects, it has produced antibodies that should prevent natural infection. Proof of its ability to prevent this natural infection in humans must await trial on many thousands of humans.

The safety of the vaccine for administration to humans has been determined and safeguarded in the best known ways.

The State Board of Health wishes to participate in the trial of this vaccine should a county or counties in the State be suitable for such field trials with the understanding again that it is a trial to determine whether or not the vaccine will prevent poliomyelitis in humans.

The State Board of Health approves the trial in either the control study or the original plan, depending upon the suitability of the area selected and the provision of laboratory facilities.

There has been some delay in the manufacture of this vaccine in sufficient amounts on account of technical difficulties in production and testing. Every batch used must meet the most rigid tests.

The Infantile Paralysis Foundation is sponsoring a program, with the aid of the State and Territorial Health Officers, for the inoculation of school children of the second grade. This program is nation-wide and we in South Carolina will participate, in one county. All school children in the second grade in the selected county will be inoculated and that the first and third grade pupils will be in the nature of control. It is also proposed that a specimen of the blood of certain of the children inoculated will be withdrawn for determination as to antibodies being present.

A new test is being developed at the University of Minnesota which gives promise of being a very important step in the use of the vaccine of polio. This test amazingly enough depends upon an unusual strain of cancer cells growing in the test tubes. Polio virus added to the tubes will grow upon and destroy the cancer cells.

A sample of blood serum can be added to the tubes first. If the blood contains antibodies, the polio virus placed in the tubes will not grow. The test can measure how strong the antibody protection is. Thus it will be helpful in determining the degree of immunity in a given specimen of blood from an individual before or after vaccination.

Our laboratory is now making quantitative tests on all positive blood sent in for serological test for syphilis, whether requested or not. This should be of interest and benefit to the profession as a considerable number of positives are found in routine examination where it is not possible to get from the patient any history suggestive of past infection. As soon as possible all qualitative blanks will be discontinued and only quantitative blanks will be furnished. This will entail an additional load on already overloaded laboratory facilities, especially on peak days of the week.

The mass Blood Testing Program has revealed some interesting figures. Of 175,956 persons tested, there were 13,021 positives found and of these 6,804 needed treatment. The average cost per person tested was \$.89 and the cost per person treated at clinics was \$22.02. The recommendation of the Executive Committee is that all positives needing treatment be treated by their physicians if they can make satisfactory financial arrangements but, if infectious and unable to pay, that pressure be exerted to have them go to the clinic for adequate treatment.

Under the Hospital Survey and Construction Act (Public Law 725 as amended) based on a \$65,000,000 appropriation for the nation, South Carolina received for the fiscal year 1953-54 \$1,583,129.00. The entire State allotment was encumbered to the South Carolina Medical College Teaching Hospital, leaving a balance due of \$1,303,351.75 to complete this project. The President has recommended a \$50,000,000 appropriation for the fiscal year 1954-55. Of this our State will receive approximately \$1,237,570.00, thereby leaving the teaching hospital project approximately \$65,000.00 short of Federal funds needed for completion. If this shortage does occur, it is expected that this amount will become available during the ensuing fiscal year thereby enabling the College to receive the full Federal amount of \$5,851,201.51 for which this project has been approved.

HR-8149, known as the Wolverton Bill, if enacted into Law, would amend the present Hospital Survey and Construction Act. The President's budget contains a request for \$60,000,000 additional construction funds and \$2,000,000 in survey and planning money to carry out the provisions of this Bill. The Bill specifically authorizes appropriations for construction of diagnostic and treatment centers, chronic disease facilities, rehabilitation facilities and nursing homes. It has been estimated that should the Bill become Law, South Carolina would receive approximately \$1,484,250.00 for the fiscal year 1954-55.

We are quite happy with the progress being made on the teaching hospital at the Medical College. While there is much work to be done on the interior of the

building, the exterior now shows that we will have a hospital of which the whole State will be proud.

There are several new hospitals still incomplete which are being constructed with Hill-Burton money. The Medical College project, which was delayed by legal difficulties, will receive most of the funds now available to this State. Several of our hospitals in the State are receiving funds for much needed enlargement.

It has always been the policy of the Federal Government in the main, after establishing worthwhile projects, to gradually withdraw financial support and to depend on State funds to take over. Acting on this principle there has been a reduction in many of the Federal allotments and, while our State appropriation has been fairly liberal, it is not enough to make up for Federal losses. Just where this will lead to in public health in South Carolina is hard to foresee.

Two years ago the Federal funds were cut by over \$200,000 after the Legislature had adjourned and thus there was no opportunity to secure a replacement. Therefore, it became essential for the counties to increase their funds to the county health departments which, in turn, allowed us to maintain a somewhat reduced but still effective central administration. For the present year, the Federal Government again cut the funds by approximately \$200,000, however, some of these funds were made up by the State and again by the counties. For the next fiscal year beginning July 1, 1954, it has been estimated by the President of the United States and by the State Health Officer that Federal funds will be cut by approximately \$175,000.

For the next fiscal year beginning July 1, 1954, the General Assembly has provided State funds in the sum of \$2,206,887, which is an actual increase of \$208,261 over the funds for the previous year. Of this amount \$157,000 was actually provided to make up what we believe will be the Federal cut and additional funds to round out certain phases of our program. In other words, we have \$157,000 to make up the proposed Federal cuts and \$51,261 for the expansion of health work.

Funds for V. D. Control have been gradually curtailed until, even for the past fiscal year, there is a minimum of such funds available and we believe that, for the ensuing fiscal year, the program will be so sharply curtailed as to interfere with its effectiveness. This is a significant statement because it probably means that the private physicians and county health departments will have to increase their participation in V. D. Control through diagnosis and treatment.

The General Assembly has gradually provided more and more funds for the county health departments until, for the ensuing fiscal year, the sum will be \$1,058,513. This is a significant statement because it indicates that the General Assembly is appreciative of their local health services.

As reported last year, we asked that the State Sanatorium be placed under a separate board as we felt more funds would be obtained for maintenance and

expansion. We note that such has been the case. This magnificent institution was developed by you under the supervision and direction of the Executive Committee and we gave it up with some feeling of disappointment and sadness.

The general tuberculosis work over the State is still being carried on in an aggressive manner and many new cases are being found. The various county health departments do a good work under the Director of the Division of Tuberculosis in discovering, hospitalizing and follow up of discharged patients from the Sanatorium and close check on contacts.

The Section maintains a Central Registry of tuberculosis cases which now contains 6,462 cases of tuberculosis. Of these cases, 4,180 are white patients and 2,282 are negroes. During the calendar year of 1953 a total of 1,178 new cases of tuberculosis, all forms, were added to the register.

Of the 2,461 active cases in the Central Registry, 1,247 cases are still in the home because, principally, hospital beds are not available for their care. Three hundred ten of these active cases at home have a positive sputum and are a constant source of danger to their associates.

Chest clinics are held in all counties of our State either continuously, weekly or monthly. In addition to persons with contact history or suspicious symptoms, and persons referred by family physicians, these local clinics attempt to furnish routine chest examinations to midwives, food-handlers, prenatal cases and many of the persons who visit the health departments for the various health services. These clinics examined 78,228 individuals and found 656 cases of tuberculosis during the fiscal year.

The continuance of pneumothorax refills after discharge from the sanatorium is most important in the post-sanatorium patients.

Although we are making strides in our tuberculosis control program, we are still confronted with several unfinished tasks, two of which are: (1) the negro death rate continues to be almost four times as high as the white death rate and the need for additional sanatorium beds is imperative and (2) there is an acute need for a more adequate form of public assistance to the dependent families of tuberculous bread winners.

As all of you know, Dr. James Adams Hayne died shortly after the 1953 meeting of our Association. It is not my purpose to eulogize Dr. Hayne in this report. His passing was duly recognized in the records of the Executive Committee. We wish again to express the high esteem in which he was held not only in South Carolina but throughout the nation. His efforts in developing public health work in this State was monumental.

We wish to express our great satisfaction in the support and cooperation of the medical profession during the past 12 months. With your aid and support the Executive Committee will continue to strive to build barriers against disease and to strengthen the lines of defense.

Respectfully submitted:
Executive Committee, State Board of Health
W. R. Wallace, M. D., Chairman

**REPORT OF COMMITTEE ON MEDICAL
SERVICE
SOUTH CAROLINA MEDICAL ASSOCIATION
MAY 1954**

Summary

1. The New Doctor Draft Law—Public Law 84
List of important changes.
2. Activities of the Office.
3. Liaison.
4. Financial Statement.
5. Outlook.
6. Appreciation.

Section I—The New "Doctor Draft Law"

A new Doctor Draft Law, Public Law #84 was passed by the 83rd Congress and approved June 29, 1953.

This law was essentially the same as the previous one except for the following main changes:

1. The law extends the present Doctor Draft Law for a period of two years, to July 1, 1955.
2. It changes the criteria for Priorities I and II by allowing credit for service performed both prior to, and subsequent to, completion of, or release from the program or course of instruction.
3. It reduces to 17 months the existing requirement of 21 months for Priority IV (a doctor in Priority II who has not been ordered to active duty who has completed 17 months of active service, will now be placed in Priority IV).
4. It extends to July 1, 1955 the period during which physicians and dentists coming on active duty may receive the extra \$100.00 per month in pay.
5. It extends the authority of The President to recall special registrants to active duty, without their consent, to July 1, 1955.
6. In computing periods of active duty or active service, credit shall be given for all periods of one day or more except that no credit shall be allowed for: periods of training service under ASTP, Army Air Corps College Training Program and similar Navy, Marine Corps and Coast Guard programs; periods spent in interne training, residency or other postgraduate training; periods of active service for sole purpose of undergoing a physical exam; periods of active service for training entered into subsequent to enactment of this law; periods of active service in the Public Health Service which terminate after April 30, 1953, without the approval of that Service.
7. It authorizes all Reserve Doctors, commissioned as a result of the operation of the Doctor Draft Law, to be given a grade or rank commensurate with their age, experience, and ability.

Section II—Activities of the Office

Requests for approval as to availability now ren-

dered on 12 men.

Seven were recommended "available". Action deferred on one man because he was 42 years of age and Priority III.

Four were declared essential.

One interne until he completed his first year.

One teacher in Medical College.

Two essential to small county because medical care would fall below a required minimum.

Numerous bulletins received and copies sent to District members of the Committee.

Notice of release for service received on some men who expressed preference to practice in South Carolina. Their names were furnished interested parties on request.

Numerous personal requests, letters, phone calls and visits from some of those affected by the Draft Law or those representing communities or hospitals. These were disposed of.

Section III—Liaison

Liaison maintained with State Selective Service Headquarters and South Carolina Military District Headquarters in matters pertaining to the Doctor Draft Law and the calling up of Reserve Officers.

Section IV—Financial

The South Carolina Medical Association Advisory Committee to State Selective Service operated at no cost to the Association. Selective Service allotments contains funds for operation of committees in each State. This covers a five hour a week stenographer, office supplies, postage and telephone. A breakdown is as follows:

	<i>Allotted By Selective Service</i>	<i>Returned to Expended Government</i>	
	1953		
Office Expenses	\$1,300.00	\$1,103.64	\$196.36
Travel	650.00	284.34	365.66
	1954		
Office Expenses	1,265.00	965.00	300.00
Travel	30.00	0	30.00
			Estimate

Section V—Outlook

The Armed Forces expect to levy a call soon. Word from Washington is that twice as many physicians will be entering military service in fiscal year 1955 as in fiscal year 1954.

Quotas are expected to be filled by available Priority I and II men and Priority III men born after August 30, 1922, that is under 32 years of age approximately. National Committee urges Internes and Residents to enter Service after completing this year and complete their Residences when they are released from Service.

Section VI—Appreciation

The Committee wishes to thank the officials and members of the South Carolina Medical Association for the fine spirit in which they have supported the Public Law 779 and its successor Public Law 84.

I want to thank our local committee members for the prompt, impartial and hearty cooperation in

furnishing information concerning matters within their jurisdiction.

Signed,

Frank C. Owens

Chairman of Committee on Medical Service
South Carolina Medical Association

REPORT OF COMMITTEE ON INDUSTRIAL HEALTH SOUTH CAROLINA MEDICAL ASSOCIATION 1953—1954

The first meeting of your Committee in the New Year was called by the Chairman. This session was held at the Medical Department, Sonoco Products Company, Hartsville, South Carolina, on January 17, 1954. The present status of industrial medicine in South Carolina was reviewed. Plans were formulated to set in motion a program which would improve the position of industrial health in our state.

Immediately following this meeting in Hartsville, a canvass was made of the membership of the South Carolina Medical Association, through the medium of questionnaire cards. The purpose of this poll was to determine those who might have a definite interest in this program. In answer to the 1100 inquiries forwarded, 256 cards expressing an interest were received.

A second meeting of the Committee was held on March 21, 1954, Hotel Columbia, at which time, arrangements were made for a state-wide meeting.

On April 4, 1954, this meeting convened at Hotel Columbia, with 40 members of the State Association in attendance. This meeting may rightfully be regarded as the first South Carolina state-wide meeting of physicians and surgeons interested in industrial health. The Chairman extended a word of welcome and outlined the overall plan of the Committee. Dr. Douglas Jennings followed with a discussion of the subject, "Guiding Principles for the Physician in Industry." Dr. Edward Gunn presented a paper entitled, "Is the Medical Profession Really Serving Man". This was truly a fine meeting. It was decided to organize an association of industrial physicians and surgeons. Officers were elected and a committee appointed to attend to certain details incident to organization, and to report back at a breakfast meeting of the group at Myrtle Beach in May.

The tremendous growth of industry in our state has definitely awakened the medical profession here to the need for a real and mutual understanding with industry. The problems to be solved are far too numerous to be described at this time. However, the first steps have been taken to give positive attention to the health of the industrial worker.

The Committee was represented officially at the Annual Congress of Industrial Health and the Joint Conference of the Council on Industrial Health, as well as a meeting of the Chairmen of the State Medical Associations' Committees on Industrial Health, sponsored by the American Medical Association. These meetings were held in Louisville, Ky., February 23-25,

1954. Dr. Gunn reported a very successful meeting. Representation at such important meetings served notice that South Carolina medicine is showing the proper interest in the medical problems of industry and the industrial worker.

It is with sincere regret that program-time for the Annual Meeting, could not be made available to one prominent national authority on the subject of Medicine and Industry. It is our hope that those who are responsible for the program of the 1955 Meeting of the Association, will provide a place for a speaker to be suggested by the Committee on Industrial Health.

The Committee was represented at the annual meeting of the Industrial Medical Association in Chicago, April 24-30. It was evident that we have a great deal to gain by closer association and cooperation with that organization.

Due consideration has been given to the composition of your Committee on Industrial Health. It is the opinion of the present members that the Committee should be expanded to a total of at least twelve members. Further, it is recommended that it should have at least one member from each of the following fields of medicine: general practice, internal medicine, general surgery, orthopedics, ophthalmology, otolaryngology, obstetrics and gynecology, dermatology, occupational medicine, allergy, radiology and psychiatry. Such a membership would provide a balanced group, to which industry and the medical profession may refer for advice and recommendations. Too, it will serve as obvious evidence of the Association's interest in Industrial Medicine.

Your Committee requests approval of its desire to arrange for meetings and to evidence cooperation with the State Chapter of the American Association of Industrial Nurses, the State Chamber of Commerce, the local representatives of the National Association of Manufacturers, the South Carolina Industrial Commission, as well as such other groups as may have an interest in the health of the industrially employed.

The Committee requests approval of its plan to recommend to the Medical College of South Carolina the need for a jointly sponsored annual institute or symposium on occupational health, of one to two days duration, to be held at the College, and to which all South Carolina physicians and surgeons would be invited.

The Committee further recommends that, the South Carolina Medical Association take an active interest in the trend of policies being effected by the American Nurses Association and its member State Nurses Associations, since there is a distinct possibility of adverse relationships between patients, physicians, and nurses, resulting from the present trend.

The Committee recommends that the South Carolina Medical Association go on record as advocating the establishment of a well-staffed and vigorous industrial hygiene program under the direction of the State Health Department.

This report indicates the breadth of action and planning with which your Committee on Industrial Health

has met its responsibilities during the past year.

Respectfully submitted

W. W. Edwards, M. D., Chairman

NEWS

At the annual meeting of the South Carolina Obstetrical and Gynecological Society at Clemson on April 3-4, Dr. Frank Geibel was nominated by the Society to succeed Dr. Guess as the State Chairman of the Maternal Welfare Committee.

At the same time, Dr. Herbert Black and Dr. W. A. Hart were renominated to act as Obstetrical consultants to the Committee on Infant Mortality.

A picture in GP for May 1954 shows Dr. William Speisegger of Charleston, and Dr. Charles Wyatt of Greenville, sitting high up in the Congress of Delegates at the Cleveland meeting and attending attentively to their duties as delegates from South Carolina.

The Coastal Medical Society held its final meeting of the season at Edding's Point Camp, Beaufort, on April 15th, with Dr. Wm. M. Bennett presiding.

The scientific presentation on Cancer of the Lung was made by Dr. John C. Hawk, Director Cancer Clinic, Medical College of S. C., Dr. Edward F. Parker, of the Medical College Surgical staff, and Dr. H. R. Pratt-Thomas, of the Medical College Pathology Department. A lively question and answer session followed the symposium.

The Coastal Medical Society, composed of some 120 doctors from Charleston, Berkeley, Dorchester, Colleton, Hampton, Allendale, Jasper, and Beaufort counties, was originally organized to provide practitioners with closer contact with specialists and the Medical College staff members, to better keep abreast with modern medicine. The Society meets monthly from September through May.

Incumbent officers for the past two years have been Dr. A. R. Johnston, St. George, President, Dr. Wm. M. Bennett, Walterboro, Vice-President, and Dr. H. M. Carter, Smoaks, Secretary-Treasurer.

At the last regular meeting of the Berkeley County Medical Society Dr. J. N. Walsh was elected president for the coming year, Dr. Reid Wyly of St. Stephen was elected Vice President and Dr. R. S. Solomon, Secretary and Treasurer. Dr. Walsh was again named Chief of Staff of the Hospital and Dr. Solomon will act as Secretary to the Hospital Staff.

The very successful program of training practical nurses was evaluated by the society and subsequent plans for the practical nurse training program were discussed by the members present.

The American College of Preventive Medicine was founded by about 50 public health doctors, private practitioners and medical school instructors.

They were meeting as the Southern section of the American Public Health Convention.

The membership will be composed of that group certified by the American Board of Preventive Medicine who are specialists in their field.

The organization may be compared to the American College of Surgeons in its field, the announcement said.

Officers include: Dr. Ben F. Wyman, South Carolina state health officer, Columbia, first vice-president.

Dr. Drayton L. Nance has recently reopened his

office in North after being away for several years. He will practice medicine at the same location which he occupied before his recall into the U. S. Air Force in July 1951.

Dr. Mary Noble Smith, Fellow of the American College of Surgeons, has opened an office at 330 E. North St., Greenville for the practice of obstetrics and gynecology. She was born in Abbeville, received her M. D. from the Woman's Medical College of Pennsylvania, practiced in Spartanburg and in New Hampshire.

DR. FISHBURNE MARKS HALF-CENTURY IN BERKELEY COUNTY

April 10, 1954, marked the 50th anniversary of the practice of medicine in Berkeley County by Dr. W. K. Fishburne of Pinopolis, beloved "Country Doctor" and County Health Officer. He is exceedingly well-known, having "borned" many of the Berkeley County children in the last half century, and is highly respected and beloved by all who know him. It has been said of him that he has two loves besides his family, of whom he is justly proud, and his profession, at which he is excellent—the first, the people of Berkeley County and the second, sports and athletics.

Dr. R. D. Hicks has now begun his medical practice in St. Matthews. Dr. Hicks and family moved from Bishopville.

His office is located at his home on East Bridge Street.

The Marion County Medical Society held its annual organizational meeting at Little Pee Dee Lodge near Mullins at which time the following officers were elected: Dr. Sam Cantey, president, Dr. Moses Edward Rice, vice-president; Dr. Sam Witherspoon, secretary and treasurer.

Dr. Ernest G. Edwards, who has been practicing in Savannah, Ga., for the past two and a half years, has opened an office at 1512 Gregg St., Columbia for the practice of orthopedics.

He was graduated from the Duke University School of Medicine in 1944, and following his graduation, interned at Duke Hospital in Durham, N. C., in general surgery and orthopedic surgery in 1945 and 1946. He also interned at the North Carolina Orthopedic Hospital for Crippled Children.

Williamsburg County Medical Association recently elected Dr. J. G. Ulmer as president.

The election came at the association's quarterly meeting, held in the A and J Restaurant.

Dr. V. L. Bauer was re-elected secretary-treasurer. Dr. Paul S. Watson of Kingstree was named a delegate to the South Carolina Medical Association meeting next May in Myrtle Beach. Dr. J. C. Montgomery was named an alternate.

The Society voted to place the magazine "Today's Health" in all high schools of the county, white and Negro.

Orangeburg Rotarians found a unique way to honoring Dr. Vance W. Brabham, Sr., one of their most distinguished members. Taking their idea from the television program "This Is Life," Rotarians, under program chairman Hugo Sims, Jr., outlined the story of Dr. Brabham's life, giving the highlights of his service to the club, to his church and to his fellow citizens of Orangeburg.

Dr. Phillips L. Bates opened his office in the Textile Building, Greenwood today for the practice of urology. He will be on the staff of Self Memorial Hospital.

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamoebic therapy."

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, *J. Iowa M. Soc.* 42:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, *California Med.* 76:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, *Rev. Gastroenterol.* 20:667 (Sept.) 1953.

4. Goodwin, I. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, *J. Pharm. & Pharmacol.* 4:153 (March) 1952.

Dr. Bates is a graduate of Furman University and the University of Rochester Medical School.

A new addition to Gaston Hospital at Travelers Rest, increasing the number of private rooms to 35, has been completed and shown to the public at an open house.

The institution, serving upper Greenville County since 1930, has been licensed by the State Board of Health as a full general hospital.

The addition, fronting about 130 feet on the main thoroughfare in Travelers Rest, cost about \$150,000 including construction, furnishings and equipment.

ANESTHESIOLOGISTS ELECT

The South Carolina Society of Anesthesiologists held its annual meeting Thursday in Myrtle Beach in conjunction with the annual meeting of the South Carolina Medical Association.

The principal address was given by Frank H. Bailey, Charleston attorney, and was entitled "Rambling with an anesthesiologist through judicial decisions of South Carolina."

The following officers were elected: Dr. W. West Simmons of Greenville, president; Dr. John C. Doerr of Charleston, vice president; and Dr. Kenneth J. Boniface of Charleston, secretary-treasurer.

Presiding was Dr. John M. Brown of Charleston, retiring president.

WOODRUFF HOSPITAL

Grading has begun on the site for the new hospital at Woodruff which will be built to serve the lower half of Spartanburg County.

The tract of 14.35 acres includes 10.85 acres purchased from the W. H. Mason estate and an additional three and half acres were donated by the family.

Dr. B. J. Workman, Sr., local chairman of the hospital planning committee, said he hoped that bids for construction could be asked for soon.

DR. H. B. SPRINGS GOES TO MULLINS

Dr. H. B. Springs has become an active member of the Mullins Hospital staff. He will open an office in the Kirby building on Wine Street for the practice of general surgery.

For nine months, Dr. Springs has been practicing surgery in Marion with Dr. William L. Cheezem, Jr. and they will continue together as partners, being active on the staffs of the Mullins Hospital and the Marion County Memorial Hospital in Marion.

Dr. John Harden, surgeon at Cannon Memorial Hospital, has recently successfully completed an examination and has been accepted as a Diplomat of the American Board of Surgery.

CONWAY

The newly expanded and renovated Hospital now provides a total of 93 beds and 18 bassinets, and will discharge over 6,000 patients during 1954.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

WOMAN'S AUXILIARY CONCLUDES SUCCESSFUL YEAR WITH "HEALTH EDUCATION THROUGH COMMUNITY SERVICE" AS THEME

"The state auxiliary has worked this year on the premise that everything that each of us does is a part of a total public relations program whether we wish it to be or not. Our activity in all phases of community life reflects upon the medical profession. By knowing our communities, by becoming aware of health facilities available in our locales, by determining whether they are being used to advantage, by uncovering the needs—our program of HEALTH EDUCATION THROUGH COMMUNITY SERVICES has been challenged. We have related every field of auxiliary activity to our community and to our planned public relations program."

The foregoing paragraph is quoted from an article by Mrs. David A. Wilson, retiring president of the Woman's Auxiliary to the S. C. Medical Association, which appeared in the May Auxiliary Bulletin. The following resume of Auxiliary activities during the past year is condensed from county auxiliary reports.

Anderson, Charleston, Pee Dee, Richland and York Auxiliaries contributed a total of \$450 to local nurses' scholarship or loan funds; an additional \$125 was given to memorial hospital or cancer funds by Greenville, Pickens, Richland, Spartanburg and Sumter auxiliaries. Very active nurse recruitment programs in every auxiliary were climaxed with a rally for future nurses at Winthrop College. Many auxiliaries presented elaborate heart education programs using television, radio, newspapers, speakers bureau, etc. to reach the public. Doctors' Day was observed in each auxiliary by impressive methods, using the red carnation as a symbol of honor to physicians. Legislation, civil defense and mental health programs were held

in the majority of auxiliaries. An album of photographs of state past presidents has been added to the archives at the library of the Medical College of South Carolina. There are no paid auxiliary members in Hampton, Jasper, Clarendon, Williamsburg, Berkeley, and McCormick counties. New auxiliaries were organized in Kershaw, Horry, and Oconee counties. Two students at the Medical College of South Carolina are receiving \$500 each per year from the Student Loan Fund; student nurses are receiving aid from the Jane Todd Crawford Memorial Nurses' Loan Fund. Contributed to these funds were \$661 and \$330.50, respectively, by the auxiliary membership.

WOMAN'S AUXILIARY CONGRATULATED ON EFFORTS IN NURSE RECRUITMENT

The following telegram was received by Mrs. Alton E. Brown, chairman of the Nurse Recruitment committee:

"MAY I AS PRESIDENT OF THE LEAGUE FOR NURSING OF SOUTH CAROLINA EXPRESS OUR SINCERE APPRECIATION TO YOU FOR THE VERY EXCELLENT CONTRIBUTION WHICH YOU AND YOUR COMMITTEE HAVE MADE TO NURSE RECRUITMENT. IT SEEMS THAT THE WORK OF THE FUTURE NURSES' CLUBS IS INVALUABLE AND SHOULD BE ACCELERATED. WITH VERY BEST WISHES FOR A SUCCESSFUL CONVENTION.

MINNIE H. BLEASE, R.N.

IN MEMORIAM

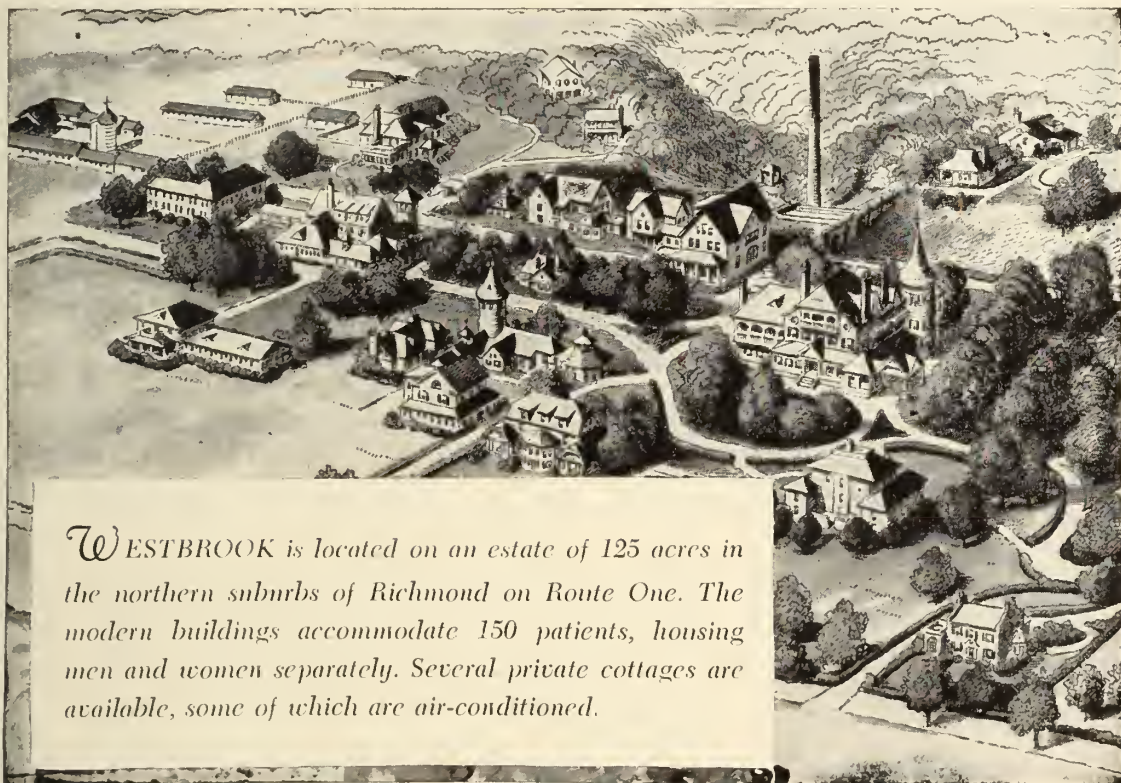
An impressive memorial service was conducted by Mrs. C. P. Corn of Greenville during the program session at the convention of the Woman's Auxiliary, with special music furnished by Mrs. Jack Jordan and Mrs. Collins Spivey of Conway. Those whose mem-



WESTBROOK SANATORIUM

Richmond, Virginia

Established 1911



WESTBROOK is located on an estate of 125 acres in the northern suburbs of Richmond on Route One. The modern buildings accommodate 150 patients, housing men and women separately. Several private cottages are available, some of which are air-conditioned.

STAFF

PAUL V. ANDERSON, M. D.
President

REX BLANKINSHIP, M. D.
Medical Director

JOHN R. SAUNDERS, M. D.
Associate

THOMAS F. COATES, M. D.
Associate

R. H. CRYTZER
Administrator

A PRIVATE psychiatric hospital for the treatment of nervous and mental disorders and the problem of addiction.

The modern diagnostic and treatment procedures include electro-shock, insulin, psychotherapy, occupational and recreational therapy.

WESTBROOK SANATORIUM

P. O. Box 1514 — RICHMOND, VIRGINIA — Phone 5-3245

Brochure of Views and Literature Sent on Request

ories were honored were: Mrs. T. E. Bowers of Charleston; Mrs. Luther W. Boggs, Greenville; Mrs. Cornelius A. Dufford and Mrs. E. H. Moore of Newberry; Mrs. J. W. Bell, Oconee; Mrs. Chapman J. Milling and Mrs. H. M. Smith, Richland; Mrs. Davis D. Moise, Sumter; and Mrs. William W. Fennell, Sr., York.

FUTURE NURSES' CLUBS HELD FIRST STATE RALLY MAY 7-8 AT WINTHROP COLLEGE

Members of Future Nurses Clubs from high schools over the state held their first convention at Winthrop College May 7-8. The rally was sponsored by the Woman's Auxiliary to the South Carolina Medical Association, with Mrs. Alton E. Brown of Rock Hill, chairman of Nurse Recruitment for the Auxiliary in charge. All high school girls interested in nursing were invited to attend whether their school had a Future Nurses' Club or not. Representatives of all schools of nursing in South Carolina were invited. Entertainment was provided on Friday evening by nurses of the York County Hospital. Saturday morning the students heard Mrs. P. V. Mikell, education director of the State Board of Nursing Examiners, speak on "Preparation for Nursing Education." Dr.

S. J. McCoy, dean of Winthrop College, discussed "You Can Have College and Nursing, Too," and June West, president of the S. C. Student Nurses Assn. and a student at the Spartanburg General Hospital spoke on "Why I Chose Nursing."

President Henry R. Sims of Winthrop welcomed the guests and Mrs. David Wilson, president of the Woman's Auxiliary to the S. C. Medical Assn. brought greetings from the Auxiliary. Saturday afternoon the group toured York County Hospital and attended a tea given by the York County Medical Auxiliary.

There are 12 Future Nurses' Clubs in the state, with 457 members. 37 of these are in a club for negro girls.

HONOR GUESTS AT STATE CONVENTION

Mrs. Paul D. Craig of Reading, Pa., director of the Woman's Auxiliary to the A. M. A., who represented Mrs. Leo J. Schaefer, president of the national Auxiliary.

Mrs. George D. Feldner, New Orleans, Louisiana, President, Auxiliary to Southern Medical Association.

Mrs. Alfred F. Burnside, Columbia, S. C., First Vice-President, Auxiliary to Southern Medical Association.

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

PROFESSIONAL LIABILITY INSURANCE CALLED "SERIOUS PROBLEM NATIONALLY"

(Frequently we receive inquiries from members of the Association in various parts of the State concerning the availability of malpractice insurance coverage at reasonable rates. Some companies have terminated their contracts and most, if not all of the others have raised the premiums drastically. It has been difficult to answer satisfactorily the inquiries received. The situation as it exists generally, and the reasons behind the current attitude of the companies writing this type of insurance are clearly set forth in an excellent discussion of the subject by an insurance expert, prepared for and published in the monthly Newsletter for May of the American College of Radiology. It is reprinted here with their permission.)

It should be recognized that hospital liability and physician's professional liability insurance have never been regarded as desirable business by the insurance companies. It has been written only as an accommodation to agents in order to supply a limited demand. There was never sufficient volume of this business available for the companies to give it more than passing attention.

Until World War II, except in cases of flagrant violations of good practice, there were very few suits for malpractice filed, and consequently very little publicity. X-Ray, being a comparatively new modality in medical practice, received considerable undue publicity and was severely penalized (rate-wise) by insurance companies. Records of 20 years in this field dispel the myth that good radiology has been any more hazardous than any other medical specialty. There have been few cases of admitted liability. Ad-

mitted liability claims can be quickly evaluated and settled without publicity. The nuisance claim is the one which runs into expense. They usually remain unsettled for years and require regular attention. The plaintiff's attorney has most often taken the case on a contingent basis; he hopes to wear the company down with an ultimate settlement in mind for less than the cost of courtroom defense. In the meantime the companies must maintain large reserves for each case and to this must be added legal expenses.

The first group malpractice insurance plan for radiologists went into effect in 1935 for members of the American Roentgen Ray Society. Later it was made available to all qualified radiologists. This program was instrumental in bringing order out of a variety of rates which were being charged by various companies depending on their individual experience. Through the past 20 years the initiation of this program has saved radiologists millions of dollars in premiums. It has also resulted in a much better understanding of the professional liability insurance problem by both radiologist and companies.

20 Years Later

There are many reasons why the entire medical profession today finds itself in the same position that radiology was in 20 years ago. Here are some of the recent causes that have gone into the pot to make hospital and physicians' liability insurance even more undesirable from the underwriters standpoint: increased demand for medical and hospital care; legislation increasing hospital liability; specialization; excessive fees; increased public "claim consciousness"; bad hospital public relations; hospitalization insurance; dollar "madness"; court interpretations broadening liability in this field; increased cost of legal work and

investigation.

The most potent factor, however, is the ever spiraling inflation and dollar devaluation—to which there seems to be no end—and which has resulted in fantastic judgments being rendered by juries in personal injury and malpractice suits.

In the early 1940's, it was rumored that London was of the opinion that inasmuch as America had adopted the Keynesian economic theories, the American dollar would ultimately reach a value of .096 as compared with the 1929 dollar. As a result of the two world wars, the Korean police action, plus the Keynesian theories, we find this undeniable corollary: a 59 cent dollar now has a 50 cent purchasing power; English currency has a value of 10 per cent of its 1914 worth; and the currency of France has a value of one per cent of its 1914 worth. With the American public demand for subsidies, pensions, social security, veterans' programs, increased wages and the possibility of our further involvement in military actions, it is difficult to see how inflation patterns can change or why companies would care to assume any liability which could not be settled within six to 12 months.

In 1945, Lloyds of London, as the result of some very heavy losses, principally in the highly industrialized areas of America and on the west coast, revised their entire scale of rates for physicians' professional liability coverage in the United States. They cancelled all group contracts and limited writings to terms of

not more than one year. Rates were practically tripled in 40 of the 48 states. It is believed that Lloyds—who are experienced in world-wide post-war inflations—anticipated the inflation which has taken place in this country since V-J Day. If there is any foundation to this opinion, then the recent action of Lloyds, effective March 1, 1954, would indicate either they expect further inflation or this is their way of bowing out of the malpractice insurance market.

Lloyds of London rates for professional liability insurance effective March 1, 1954, are as follows for Florida, Illinois and New York:

Limits \$25,000-\$75,000

Physicians (No surgery, radium, or x-ray therapy and diagnosis)	\$230.00
Surgeons	360.00
Radiologists (doing surgery)	690.00
Radiologists	575.00
Each employed radiologist (no coverage for employee) add	460.00
Each technician (no coverage for employee) ..	115.00
NOTE: Add 33-1/3 per cent to the above for California rates. For all other states, deduct 25 per cent from the above.	

In 1945, the St. Paul-Mercury Indemnity Company, which is not a member of the National Bureau of Casualty and Surety Underwriters, entered into a contract with the American College of Radiology under which members of the College could purchase

ATTENTION RESIDENTS — INTERNES

ARE YOU CONTEMPLATING ENTERING PRIVATE PRACTICE SOON? WE CAN EQUIP YOUR OFFICE COMPLETE. THE FOLLOWING ON DISPLAY—

CONSULTATION ROOM
FURNITURE

EXAMINING & TREATMENT
ROOM FURNITURE

SHORT WAVE DIATHERMY

SCIENTIFIC EQUIPMENT
DIAGNOSTIC EQUIPMENT
LABORATORY SUPPLIES
SURGICAL INSTRUMENTS
FRACTURE EQUIPMENT

We invite you to our stores. Let our SPECIALLY TRAINED PERSONNEL help you make your selection. SEE what you BUY, BEFORE you BUY IT.

VISIT US AT YOUR CONVENIENCE. WRITE, WIRE or TELEPHONE IF YOU DESIRE NIGHT or WEEKEND APPOINTMENT.

COMPLETE stocks of HAMILTON, NU-TONE, NU-TREND and STEEL-TONE.

We service what we SELL. Terms to suite everyone.



Microtherm



W i n c h e s t e r

CAROLINAS HOUSE OF SERVICE



Winchester Surgical Supply Co.

119 East 7th St. Tel. 2-4109

Charlotte, N.C.

Winchester-Ritch Surgical Co.

421 W. Smith St

Tel. 5656

Surgical Co.

Greensboro, N.C.

professional liability insurance. The rates were somewhat less than the rates of the Lloyds' contract which had just been cancelled. The College - St. Paul - Mercury contract was discontinued by the company on May 15, 1953. The writer has been advised that the company is offering to renew some of the policies at the rates established by the National Bureau of Casualty and Surety Underwriters, but in some areas the rate is considerably higher than that required by the Bureau.

Effective—Oct. 1, 1952, the Bureau of Casualty and Surety Underwriters, to which practically all of the older and larger companies subscribe, promulgated rates for hospital and physicians' liability coverage for the various states. These rates have been filed and either accepted or rejected by the insurance departments of the various states. The rates are binding on all member companies. *This does not necessarily mean that these companies will underwrite professional liability coverage in all states.* For instance, we know of no American company that is underwriting new insurance for radiologists west of the Rocky Mountains.

Some Write It—Reluctantly

Some few of the companies are reluctantly writing business at the Bureau rates. One company will write for only their own agents and will cover x-ray therapy, providing the assured has been certified by the American Board of Radiology or is a member of the American Roentgen Ray Society or the Radiological Society of North America. Another company will write for its own agents only and will not write or renew existing policies for brokers. In addition, the applicant must promise the company all of his insurance business as collateral.

The Bureau rates range from \$50.00 in Pennsylvania, \$63.00 in Illinois, \$88.00 in Kentucky, \$188.00 in New York and \$250.00 in California for basic limits of \$5,000.00/\$15,000.00. For limits of \$25,000.00/\$75,000.00, add 71%; \$50,000.00/\$150,000.00 limits, add 89%; for \$100,000.00/\$300,000.00, add 106%. For each employed radiologist add 50% (this additional charge does not cover personal liability of assistant if he is personally sued) for each x-ray therapy technician add \$8.00 to basic premium. In cases of partnerships, add 50% to each partner's premium to cover partnership liability.

In all probability Lloyds' recent action will have repercussions in the American insurance market in the not too distant future. It is doubtful if our domestic companies will wait seven years as they did following Lloyds' action in 1945.

We regret that we have no solution to offer. Several suggestions for relief have been made which might bear further thought and study.

WHITTEN VILLAGE

B. O. Whitten, M. D., Superintendent
Clinton, S. C.

Institution with above title has good position to offer as Clinical Director to young, capable physician, preferably a South Carolinian but not necessarily. Person logically succeeds to Superintendency in few years, or refuses that office at his discretion. Anyone interested, communicate with the undersigned.

B. O. Whitten, M. D.
Superintendent

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

A course in "Newer Developments in Cardiovascular Diseases" will be given at The Mount Sinai Hospital, New York, October 11th through 15th, 1954, under the auspices of the American College of Physicians. As the title implies, the recent advances will be stressed. Dr. Arthur M. Master and Dr. Charles K. Friedberg will direct the course and prominent cardiologists and cardiac surgeons will participate.

The Department of Otolaryngology, University of Illinois College of Medicine, announces its basic science course in otolaryngology offered by its affiliated hospitals. This combined postgraduate course and residency will begin its 1954-55 session on July 1, 1954. Other openings occur throughout the year. Residencies are available at either the Research and Educational Hospital or the Illinois Eye and Ear Infirmary, or a continuation of the training program may be arranged for the Veterans Administration Hospital at Hines.

A stipend is offered on the following basis:

First year residency ----- \$1320 annually

Second year residency ----- 1620 annually

Third year residency ----- 1920 annually

Application forms are available on request to the Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12.

The Journal

of the

South Carolina Medical Association

VOLUME L

July, 1954

NUMBER 7

Address of Governor James F. Byrnes

When your president invited me to address this meeting, I determined to speak to you about your public relations and your public obligations. I had just read in Fortune Magazine Herrymon Maurer's article, "The M. D.'s Are Off Their Pedestal." A few months earlier I had read a story in Collier's entitled, "Why Some Doctors Should Be In Jail."

I confess I was disturbed. I was one of those who through the years had placed the doctors on a pedestal. I had read the oath written by Hippocrates which is taken by those who would practice medicine.

Some years ago, when Columbia University conferred an honorary degree upon me, I listened to a very large graduating class in the School of Medicine take that oath. It made a tremendous impression upon me. As I listened to it, I thought of the hundreds of doctors I had known in a reasonably long life. I could recall only a few who, in my opinion, had violated the obligations of that oath. It has served as an inspiration and as a guide. Its standard of ethics is as lofty today as it was 2,000 years ago.

Disregarding the arguments of Mr. Maurer in his magazine article, let us consider for a moment whether or not he is correct in his statement that doctors were on a pedestal.

I think they were, and rightly so. The man who devoted all of his time, talents and energies to the accumulation of money either in the legal profession, in the banking business or manufacturing business envied the physician who without possessing money, possessed what money could not buy, the love and devotion of his patients and his neighbors. Our opinions are always influenced by our personal experiences. I recall that when I was a member of the United States House of Representatives my sister was seriously ill and was a patient in Providence Hospital, a few blocks from the Capitol. I visited her every afternoon. One afternoon as I left her room in the hospital and met several physicians who had been calling upon their patients, I thought of how I had spent my day. On the floor of the House I had been engaged in debate about an appropri-

tion for some project in a western state. I thought the appropriation excessive. I was successful in reducing the expenditure. My common sense told me the Senate would increase the appropriation, and during that day I had accomplished very little. On the other hand, the doctor I met in the hospital had accomplished something. He may have prolonged the life of a human being. If he did not prolong life, at least he had lessened suffering. He had given hope to a patient and happiness to the loved ones of that patient. I was envious of the doctor because of the good he had done during the day as compared with my lack of accomplishment. In my thinking I placed the doctors on a pedestal.

I am sure that my feeling was shared by all right-thinking people in this state. We rightly placed the doctor upon a pedestal. He disregarded the regulation of hours of work. Day and night he answered the calls of his patients. His fees were small and he made little effort to collect even those small fees.

Then there came the threat of socialized medicine. The British adopted it. The left-wingers in this country eagerly seized upon it as a vote getter.

When President Truman advocated the plan, which the doctors of the nation properly regarded as socialized medicine, it was argued in support of the plan that President Roosevelt had advocated socialized medicine. That was not correct.

Shortly after the Labor Government of Britain had adopted socialized medicine, President Roosevelt told me he was being urged by some of his friends to sponsor such a proposal for this country. I presented to him as well as I could the arguments against such a proposal. He told me he was not committed to it.

About one week before the election in 1940, while I was in Indianapolis, Senator Minton of Indiana and Senator Clark of Missouri advised me that at a meeting of doctors then being held in Chicago there was pending a resolution severely criticizing Roosevelt for having pledged himself to advocate socialized medicine. I communicated with President Roosevelt who told me that on the following day he

would take occasion in making a speech on behalf of the Red Cross to deny that he had made any commitment to support a plan for socialized medicine. He made such a statement. It was accepted in good faith by the medical profession.

The following January the President invited me to his office, stating that Secretary of the Treasury Morgenthau was coming to urge him to include in his message to the Congress a recommendation in favor of socialized medicine, and he wanted me to answer Morgenthau. I did so. I reminded him of his Red Cross speech the previous November. I assured him the Chairmen of the House and Senate Committees would oppose it and challenged Morgenthau to telephone them. At the conclusion of the conference President Roosevelt refused to recommend to the Congress any plan for socialized medicine.

But the leftwingers continued their propaganda. They were aided by war developments. The scarcity of physicians at home during the war and the surplus of money in the pockets of the people served to tempt some members of the profession. They greatly increased their fees. Their increasing prosperity was evident. They attracted attention because doctors were proverbially poor. But these free spenders were relatively few, and I deny that these few doctors were responsible for the criticisms of the whole profession.

It was unfair criticism. A man would speak of how much he spent because of the illness of his wife or child and would invariably hold the doctor responsible. He did not criticize the hospital that was run by the county. Because the doctor had sent the patient to the hospital, he held the doctor responsible for the increased cost of hospitalization.

Now human beings differ. The conduct of doctors in different communities differ. The doctors did not overnight change their habits in every community in the United States. The fact that in a few years these attacks were made simultaneously in every section of the country indicates they were the result of national propaganda intended to support a political policy which was deemed by professional politicians to be effective in securing votes.

The threat of socialized medicine has disappeared with the election of President Eisenhower who has consistently opposed it. However, the campaign against the doctors has not disappeared and we may as well realize that the doctors must answer the misrepresentations of their critics and present their cause to the people.

I know that doctors send more patients to the hospital than previously because the new

drugs make it wise to follow that course. I know that sulfa drugs and penicillin affect different people in different ways. It is essential to give those drugs but safer to administer them when patients are in a hospital where they can be watched by nurses and interns. I am sure many people do not know that. They argue that doctors send patients to the hospital solely for their own convenience.

I know that the cost of drugs like everything else has increased. However, many patients charge up all these increases to the doctors.

I think it is incumbent upon state and county Associations as well as the American Medical Association to try by a campaign of education to correct the false impression created by the propaganda of the leftwingers.

We must not let the enemies of the profession create the impression that the progress that has been made in the treatment of disease and the increase in the length of lives of our people is due entirely to new drugs. These drugs could not be administered except by physicians.

Yesterday the United States Department of Public Health announced that as of 1951 the life expectancy of the average American was 68½ years, a gain of four years in the past decade. Whatever progress is being made or will be made in prolonging life and lessening human suffering will be due chiefly to scientific medicine practiced by the doctors of the nation.

The doctors must answer the misrepresentations of their critics. And the doctors of the state cannot hold themselves aloof from the life of the community and the state. They must, like all other citizens, take an interest in city, county, and state governments. They have great power and influence, and they should exercise it for their own good and the good of the people.

Three years ago I determined we should improve conditions at the State Hospital for the mentally sick. The facilities afforded those unfortunate mental patients were truly shocking. Some members of the profession ably supported my requests to the Legislature for appropriations. Today we have not only modern equipment but a more efficient staff. Now I am proud of that institution.

I am also indebted to many doctors for supporting my request for an appropriation to build a dormitory for Negro women at the State Tuberculosis Hospital and for the appropriation to provide a training school for mentally defective Negro children.

I am particularly grateful for your assistance in our efforts to complete the Medical Center in Charleston. Much of the criticism of doctors and the fees of doctors will disappear when we

have more doctors.

I know that your interest in government is not confined solely to such activities as the hospitals and the Medical College. As South Carolinians you are interested in every phase of your state government.

Our state is growing and prospering. The per capita income of our people from 1929 to 1952 has increased 336% while the increase for the Southeast was 225% and the increase for the nation only 141%. Our population is increasing, the latest estimate being 3.9% since 1950. You, more than any other group of men, know that in the state we have a higher percentage of children than most states of the union.

In addition to this normal growth, new industries have brought people to the state. Those industries have also served to keep young people from leaving the state in order to secure jobs in industry.

With a growing population and an increasing per capita income, more services are demanded of government by the people. The man who dreams of our returning to "before the war expenditures" and "before the war taxes" should wake up and realize he will never again see them in this fast-growing state.

The truth is that most people do not seriously complain of state taxation if they are satisfied their neighbors are paying their proportionate share and the money is being honestly spent.

When the sales tax was levied, the legislature repealed the emergency one cent tax on cigarettes and beer. It also increased the exemption on income taxes so that many people in the lower income bracket are not now required to pay an income tax to the state. These reductions in taxes amounted to approximately \$8,000,000 annually.

The legislature also provided that the sales tax could be used only to defray expenses of the public schools. That year, 1951, the state aid to public schools amounted to little more than \$35,000,000. This year the public schools cost the state more than \$65,000,000. The Sales Tax lacks \$20,000,000 of paying school expenses.

The increase in school costs is not due entirely to increased salaries for teachers. There are many things like the cost of transporting students to school, which was previously borne by counties, now paid for by the state.

In addition, the number of students being transported to school increased from 142,000 in 1951, to 203,000 for the 1953 school year. This obligation formerly paid largely by the counties is now paid by the state and costs \$4,400,000 annually, plus the cost of purchas-

ing new busses each year.

In addition, from funds collected by the state, there has been sent back to the counties this year in cash more than \$12,000,000. This should lessen in some degree your county taxes.

I do not want to bore you with statistics, but it is important for you to know that while the state collects more money than it formerly did from the taxpayers, it has assumed obligations previously discharged by the counties.

New industries locate in a state only if the owners are satisfied the tax structure is reasonable and there is a stable government with officials of the highest character, possessing courage and capacity.

Only a week ago the Vice President of the Mohawk Carpet Company in discussing the decision of his Company to build one plant, and possibly others, in the state said that before reaching a decision he had investigated conditions in seven southern states.

He said his company decided in favor of South Carolina because taxes were more reasonable and the government more conservative. This gentleman was not running for office. He was telling why he invested his money and the money of his company in this state.

When we are devoting our time and energies to the effort to bring into the state new industries that will furnish jobs to people and will share with us the burden of taxation, it is not helpful to have the press or the politicians frighten industrialists away from the state by uninformed statements that in South Carolina they will have to pay higher taxes than are paid in other states.

Some thoughtless person may criticize your state government, but I am proud of the fact that our state finances are in such sound condition that the leading bankers and investors of the nation will lend money to South Carolina at a lower rate of interest than is paid by most of the states of the Union.

I speak to you of state affairs and refer to your obligations to the public, but I would not want you to construe my remarks as meaning that I think it is your duty to become candidates for public office. I would not want you to suffer that burden. However, I know that you are as much interested in your government as any other group of citizens. I know too that you can exercise great influence in your respective communities. I hope you will exercise that influence in behalf of candidates for public office who possess character and dignity, courage and capacity. By doing that you will discharge your obligation to the public and will contribute to the progress of the state we love.

The Changing Epidemiological and Clinical Pattern of Pulmonary Tuberculosis

DAVID T. SMITH, M. D.
Professor of Bacteriology and Associate Professor of Medicine
Duke University School of Medicine
Durham, North Carolina

Fifty years ago, tuberculosis was the chief cause of death in Europe and in the United States. The death rate in the northeastern industrial states was nearly 200 per 100,000 and almost everyone had a positive tuberculin reaction by the age of 20. Most of the deaths were in infants and young adults between the ages of 15 and 35. The death rate was relatively lower in individuals over 40 years of age.¹

It is probable that the infection rate and the death rate in South Carolina was never as high as it was in the northeastern states. Our people had a higher standard of living, not in cash money, but in home grown food, fresh air and living space. The sanatorium system and case finding clinics were slow in developing but probably produced a greater relative effect because the relapsing cases had less opportunity to spread the disease in a rural or semi-rural areas. In spite of these advantages tuberculosis remained the chief cause of death until the nineteen twenties.

Although there has been a most gratifying decline in deaths from tuberculosis between 1920 and 1950 the crude death rate is not an accurate measure of the magnitude of the tuberculosis problem in this state. The decline in deaths has resulted primarily from (1) earlier diagnosis, (2) improved medical and (3) improved surgical treatment and not from any spontaneous loss of virulence in the tubercle bacillus. In assessing the tuberculosis problem it is important to remember that new cases have not declined proportionally to the decline in deaths. In fact, the number of new cases for each annual death, which was formerly about 3 to 1, is now closer to 10 to 1.

Changes Between 1920 and 1950

The changing status of the tuberculosis

problem can be visualized by inspecting the curves shown in figures 1, 2, 3 and 4 where the death rates have been charted by age for white males, white females, Negro males and Negro females for the years 1920, 1930, 1940 and 1950.* The most striking change has been the rapid decrease in deaths during infancy, the very low death rate in childhood, disappearance of the peak of deaths in the white between the ages of 15 and 35 and the rapid rise in deaths in white males after 44 and white females after 64 years of age.

The peak at 25 to 35 is still visible in the 1950 curve of the Negro but significantly decreased so that tuberculosis in Negroes in 1950 was less frequent than it was among whites in 1920. The relative improvement has been greater in the Negro population than in the white population although the Negro has a greater racial susceptibility to fatal disease even when the environmental factors are the same.

Tuberculosis in the Negro Population

In Roth's studies² in Negro soldiers and white soldiers between World War I and World War II the attack rate for tuberculosis was 210 per 100,000 for the white soldier and 256 for the Negro soldier while the death rates for whites was 24 and for the Negroes 99. This gives a ratio of approximately 4 to 1 in favor of the whites.

In Charleston County the death rate from tuberculosis among Negro slaves was actually lower than in the white population between 1822 and 1848. Infection was prevented among the slaves by strict isolation in slave quarters. After the slaves were freed, the contacts in-

*I wish to thank Dr. Frank Geiger of the South Carolina State Board of Health for the data from which the 1950 curves were made.

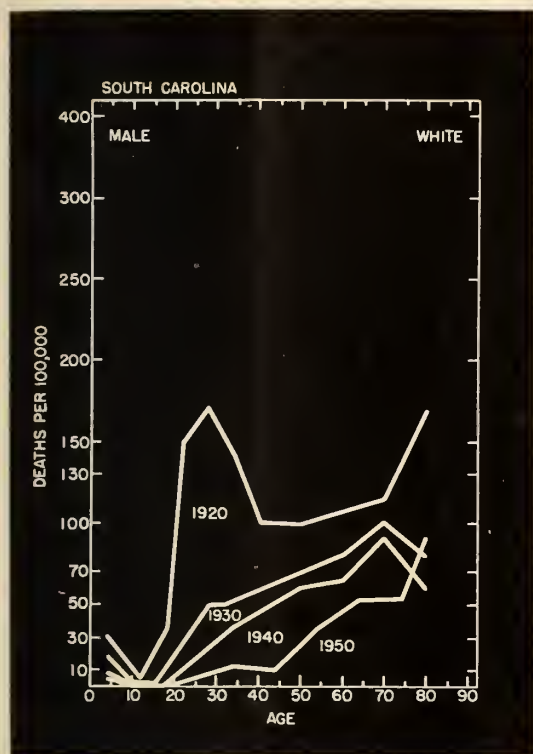


FIGURE 1

Death rate in white males by age in 1920, 1930, 1940 and 1950. Note the reduction in infants, the disappearance of the high rate from 16 to 30 and the rapid increase in the death of males after the age of 40 in the 1950 curve.

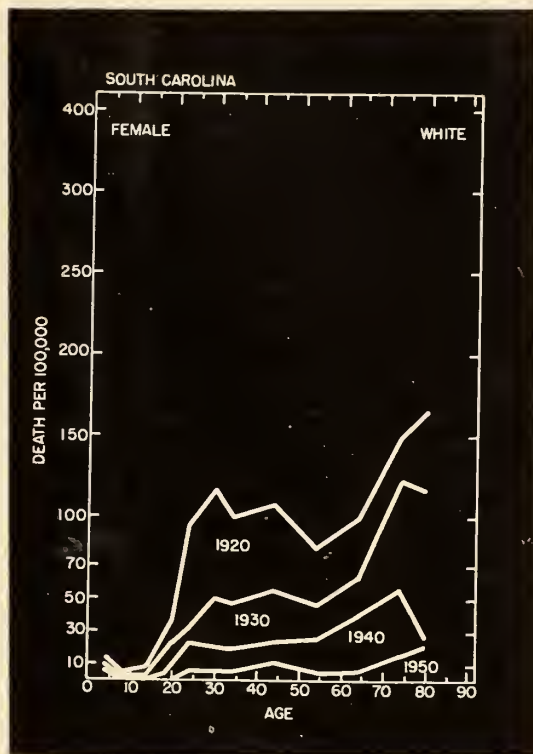


FIGURE 2

Death rate in white females by age for 1920, 1930, 1940 and 1950. Note the decrease of deaths in infants and the disappearance of the high rate between 15 and 30. There is an increase in female deaths after the age of 60.

creased, the actual standard of living went down and these factors combined with the increased racial susceptibility sent the death rate of 250 in 1848 to 670 in 1884. The decline in deaths from tuberculosis in Negroes shown in figures 3 and 4 have been accomplished in a single generation and could not have been caused by an increase in racial resistance and hence, must be attributed to the twin factors of improved standard of living and the present tuberculosis control program.

The handicap of increased racial susceptibility is being compensated for by the new chemotherapy and improved surgery. Several Veteran Administration Hospitals, which treat both white and Negro patients, report there is little, if any, difference in the curative rate between the two races.

Tuberculosis in the Adult

The sharp decline in deaths in infancy and childhood has been accompanied by an even more striking reduction in the number of chil-

dren and young adults who show a positive tuberculin test. In effect, we are approaching a situation where primary tuberculosis is shifting from the domain of the pediatrician to that of the internist and the general practitioner. Primary infections may be found in adults of any age even up to 80. Fortunately the primary infections in adults, as in children, are usually asymptomatic and are detected only by a change in the tuberculin reaction from negative to positive.

A small percentage of primary infections but actually an increasingly greater number of patients will develop progressive generalized disease which is usually fatal unless diagnosed correctly and treated with specific chemotherapy.

The patients present evidence of a generalized disease with lymph node involvement which may be in the neck, hilar region of the lung or in the abdomen. The spleen is frequently, but not always, palpable. There is

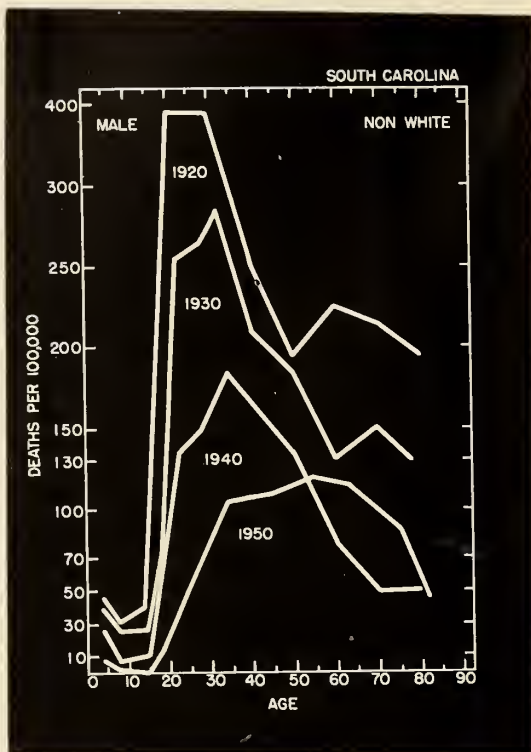


FIGURE 3

Death rate in colored males by age in 1920, 1930, 1940 and 1950. Note the reduction of deaths in infants and the marked decrease of deaths from 15 to 30. The death rate is relatively lower after the age of 40.

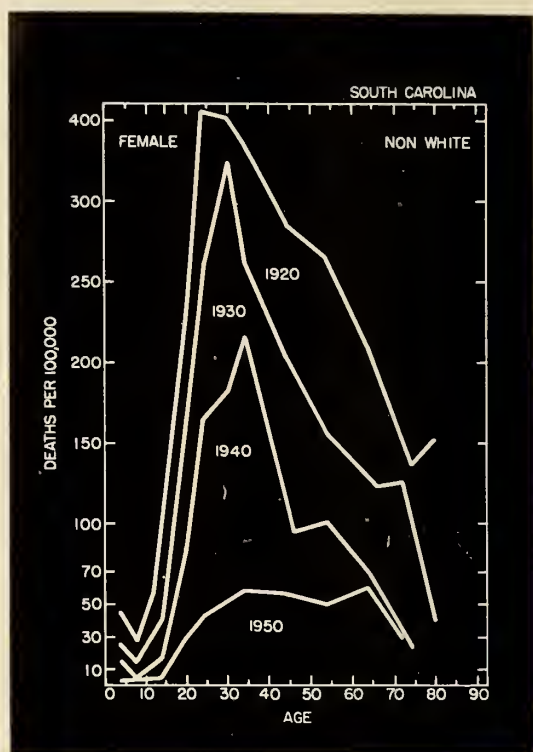


FIGURE 4

Death rate in colored females by age in 1920, 1930, 1940 and 1950. Note the reduction of deaths in infants and the marked decrease of deaths from 15 to 30. The death rate is relatively lower after the age of 50.

almost never involvement of the upper portions of the lung and the sputum is rarely positive even in terminal cases. There may be chills and fever but more frequently the fever is low and is occasionally absent for months during the earlier stages of the disease. Patients may live from one to four years before eventually dying of the disseminated infection.

The picture presented by these cases of primary infections in adults are totally disseminated to that of ordinary reinfection tuberculosis and it is not surprising that they are usually diagnosed as (1) Hodgkin's disease, (2) lymphomatosis, (3) generalized carcinomatosis or (4) fungus infections.

The following four brief case reports illustrate the varied clinical pictures presented by these primary infections in adults. Our next four patients were each different from each other and from the reported cases.

Case Reports

Case 1. A 60 year old white man was admitted to the hospital in February, 1940, with a mass in the

right lower quadrant. A diagnosis of appendiceal abscess was made and confirmed by operation 2 months later. The patient recovered from the operation but became progressively more anemic and did not respond to iron, liver extracts or multiple blood transfusions.

A filling defect found in the region of the ileocecal valve by barium studies persisted throughout his illness.

The lungs were normal for the first 2 years, but during the last 2 years small, round discrete areas appeared in the chest films. Some of these areas decreased in size; others seemed to change in shape and outline, and new ones appeared from time to time.

The patient had fifteen admissions for aplastic anemia over a 4 year period and finally died in circulatory collapse.

At autopsy tuberculous ulcers were found in the colon. The mesenteric, retroperitoneal and mediastinal lymph nodes were caseous and contained tubercle bacilli. The spots in the lungs were tuberculous lesions. The spleen was enlarged and contained miliary tubercles. The bone marrow from the humerus was essentially normal.

Case 2. A 40 year old white woman suddenly became ill 6 weeks before her first admission with chills, malaise and a temperature of 103 to 104° F. After

penicillin therapy for 2 weeks and streptomycin for 1 week, the fever was reduced but not eliminated.

On admission in October, 1946, the patient apparently was chronically ill, with slight tenderness in the epigastrium and the upper quadrant. A roentgenogram of the chest showed a mass in the superior portion of the right hilus and another smaller mass in the left hilar region.

Small doses of x-ray, followed by large doses, were applied over the hilar masses. The masses slowly disappeared, and 3 months after admission she was discharged afebrile and apparently improved.

During the next 3 months at home some lymph nodes appeared in the neck but disappeared spontaneously. The discomfort in the right upper quadrant continued, and a new area of pain appeared beneath the lower third of the sternum.

Barium studies during the second admission in March, 1947, showed indentations in the esophagus suggestive of pressure by lymph nodes. She received 1250 r over this area and was discharged.

A low-grade fever persisted from March to July, and then a slight non-productive cough, hoarseness and some difficulty in swallowing developed.

During the third admission in July, 1947, an x-ray film of the spine showed slight narrowing between the fifth and sixth cervical vertebrae. An examination of the larynx revealed a paralysis of the right vocal cord. A tuberculin test was performed, for the first time, and found to be positive in a 1:1,000,000 dilution of old tuberculin. Desensitization to tuberculin, beginning with a 1:100,000,000 dilution and progressing to 1 cc of 1:1,000,000, was attempted.

The patient returned home, where she received 1 gram of streptomycin daily for 6 weeks. Striking improvement occurred while the streptomycin was being taken and for a few weeks after it was discontinued. She became afebrile, felt quite cheerful and returned to work on a part-time schedule. By November, however, severe pains appeared in the mediastinal region, which required Demerol as often as three times a day.

During the fourth admission, between January 6 and 12, 1948, she seemed quite well and was afebrile, but x-ray study showed a destructive lesion with partial collapse of the fourth thoracic vertebra.

The fifth admission, between January 28 and February 7, was characterized by low-grade fever and bilateral pleuritic pain.

The final admission was on July 15. The patient gave a history of being almost well in March and April, but developed fever and vertebral pain in May. Streptomycin treatment for 3 weeks produced a remission, but a relapse soon occurred and streptomycin now was ineffective although continued for an additional 4 weeks.

Physical examination showed the patient to be quite ill, and the abdomen was distended and tympanitic. The diaphragm was definitely elevated on the right, and films of the abdomen indicated that both liver and spleen were enlarged. She died on July 25, approximately 2 years after the beginning of her illness.

Autopsy revealed the residue of a primary tuberculous infection in the right upper lobe of the lung, scarred and fibrotic hilar lymph nodes and scarred and partially healed lymph nodes along the esophagus, and in the abdomen at the hilus of the liver. One of these lymph nodes was adherent to the stomach on one side and to the liver on the other. A rupture of this node into the stomach made a pathway for pyogenic organisms, which caused a large nontuberculous abscess in the liver. The destructive lesions in the bodies of the vertebrae were tuberculous and not neoplastic.

Case 3. A 30 year old white man moved from a rural area into an industrial center. About 6 months later malaise, a low-grade fever and a slight generalized lymph-node enlargement developed. A roentgenogram of the chest showed a definite widening of the mediastinum, and a diagnosis of lymphoma of the Hodgkin type was made (figure 5). A biopsy of a peripheral lymph node showed a granulomatous re-

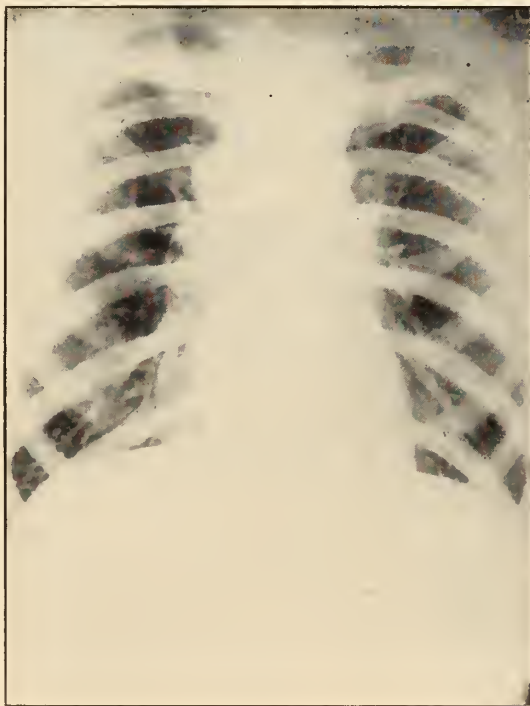


FIGURE 5

Roentgenogram of the chest showing enlargement of the hilar lymph nodes and widening of mediastinum in case 3.

action and definite tubercle formation. The clinicians interpreted the finding of tubercles in the lymph node as incidental and reaffirmed the diagnosis of lymphoma.

The course of the disease, which was insidious in its beginning, now became more fulminating. There was marked malaise, anorexia, a spiking temperature and loss of weight. The patient became comatose and died 1 week later. The duration of the acute phase of the disease was a little over 8 weeks.

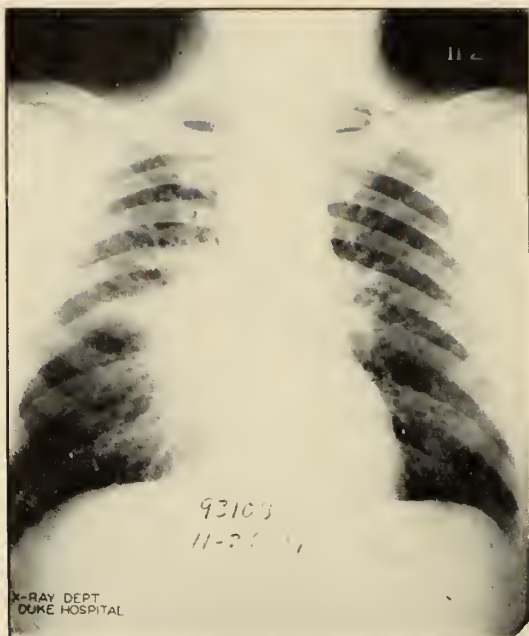


FIGURE 6

Roentgenogram of the chest, showing widening of the mediastinum and enlargement of the hilar lymph nodes in case 4.

Autopsy showed the presence of large caseous hilar lymph nodes, an enlarged, infected spleen, tuberculous meningitis and terminal miliary tuberculosis.

Case 4. A 51 year old white man noticed, over a period of 4 months, malaise, low-grade fever, anorexia, loss of weight and periodic chilly sensations without frank chills.

Physical examination showed a slight, general enlargement of all peripheral lymph nodes, and the ankles were moderately swollen and definitely red. No abnormalities were detected in the examination of the heart and lungs, but the spleen was palpable. A roentgenogram of the chest showed the widening of

the mediastinum and enlargement of the hilar lymph nodes, with some diffuse peribronchial thickening (figure 6).

The temperature was 103° F., the pulse was 104 and the respirations 22; the blood pressure was 126/70.

A tentative diagnosis of inoperable bronchogenic carcinoma or lymphoma of the lymphosarcoma type was followed by a therapeutic trial of 1500 r.

The hilar infiltration increased slowly over a 10-week period. The temperature remained between 103 and 104° F. for 8 weeks and then became remittent for the last 2 weeks. A noma-like lesion appeared on the right cheek during the 5th week of hospitalization. Final examination of the blood on the day before death showed a red-cell count of 2,630,000, with a hemoglobin of 7 gm. (49 per cent), and a white-cell count of 2,240, with 21 per cent segmented neutrophils, 33 per cent stab forms, 27 per cent juvenile forms, 12 per cent large lymphocytes and 6 per cent small lymphocytes.

Autopsy revealed a primary tuberculous pneumonia in the lower lobe of the right lung, caseation of the mediastinal lymph nodes, generalized tuberculosis of the lungs, liver and spleen, serofibrinous tuberculous pleurisy and secondary fusospirochetal gangrene of the right cheek.

Summary

Tuberculosis is shifting its chief attack from infants and young adults to middle age and elderly adults. Primary infections are appearing with greater frequency in adults and present clinical pictures are unlike those of ordinary reinfection tuberculosis in the adult.

REFERENCES

1. Smith, David T.: Tuberculosis today and tomorrow. *Am. Rev. Tuberc.*, 67:707, 1953.
2. Roth, R. B.: The environmental factor in relation to high Negro tuberculosis rates. *Am. Rev. Tuberc.*, 38:197, 1938.

The Differential Diagnosis of Lung Cancer^{*}

ROLLIN A. DANIEL, JR., M. D.

The acute bacterial diseases of the lungs are now so well controlled by the use of antibiotics and chemotherapeutic agents that they have come to be of minor importance. Lobar pneumonia, which accounted for the death of many thousands of persons each year until these agents came into use, is now aborted and is encountered so rarely that most residents in training have never seen such a patient. Furthermore, the serious sequelae of the pneumonias, such as the post-pneumonic acute empyema which in turn might be complicated by bronchopleural fistula, chronic empyema with resulting cicatricial fixation of the lung, purulent pericarditis, septicemia and pyemia are now encountered very rarely. Even the dread lung abscess which until ten years ago was a lesion which occurred rather commonly either as the result of bronchial obstruction following aspiration or from an uncontrolled necrotizing pulmonary infection, is a rarity. The lung abscess, when it is encountered today, is much more apt to be associated with and secondary to bronchial obstruction caused by cancer, granulomatous lesions of the bronchi, bronchiectasis and the like.

The pulmonary diseases which require most attention at this time, then, are those of a more chronic nature; bronchogenic carcinoma, bronchiectasis, pulmonary tuberculosis, the fungus infections, sarcoidosis, the virus infections, congenital malformations, benign tumors and cysts and various granulomatous lesions of extrinsic origin are the more common. Many of these diseases are amenable only to surgical therapy.

The rapid and alarming increase in incidence of pulmonary carcinoma among our aging population makes this perhaps the most important of the intrinsic lesions of the lung with which we are now confronted. The problem of its treatment is difficult and should offer a chal-

lenge to all physicians, because the rate of cure of this form of cancer is discouragingly low. Surgical extirpation offers the only present hope of cure. In our experience more than half of the patients whom we see with bronchogenic carcinoma are inoperable and of the remainder the majority die of recurrence of the neoplasm within two years following radical pneumonectomy. Less than 25 per cent of patients subjected to pneumonectomy have survived for five years or more.

The statement is often made that there are no "early" symptoms of bronchogenic carcinoma. This is often true. We should be acutely aware, however, that the diagnosis of lung cancer is too often made long after the appearance of symptoms which are directly caused by the growth of the tumor. The earliest symptoms produced by the growth vary and are dependent upon the location of the tumor. The most common type of lung cancer is the epidermoid carcinoma which arises in the bronchi. The earliest subjective evidences of the growth are, unfortunately, apt to be considered lightly by the patient and too often by his physician. The simple listing of these symptoms is not helpful. They are cough, wheezing, and a feeling on the part of the patient that he is not well. These troubles are commonplace and are usually mild at first. Hemoptysis, weight loss, pain and dyspnea are all apt to be late symptoms. The production of sputum is very variable.

How, then, can we improve the situation as regards the treatment of cancer of the lung? Until more accurate specific methods for the diagnosis of cancer are developed, we must rely upon our own clinical abilities. Bronchoscopic examination, biopsy of intra-bronchial lesions and cytological examination of the sputum are methods which, if employed properly, will lead to a positive diagnosis in the majority of cases where carcinoma is present. Exploratory operation is justifiable whenever the suspicion of malignancy exists and the

^{*}From the Department of Surgery, Vanderbilt University School of Medicine, Nashville, Tennessee.

diagnosis is not clear-cut without operation. These methods of investigation are too often applied to patients in whom symptoms of pulmonary disease have been present for weeks or for months, however, and where the symptoms have been ignored or misinterpreted by both the patient and his physician.

Carcinoma of the lung is most commonly encountered in men, though it is not rare in the female. Its incidence is high in the fifth, sixth and seventh decades of life. Although cough caused by "bronchitis", "flu" or so-called "virus pneumonitis" is common, the persistence of cough following these common upper respiratory infections and the presence of wheezing are unusual. The persistence of these symptoms, often accompanied by a vague feeling of malaise and of discomfort in the chest, may cause the patient to seek advice from his physician. *This first visit may prove to be the most important contact between the patient and a physician.* If the question of carcinoma is considered by the doctor, the opportunity for definitive treatment may be grasped while the lesion is removable. If, on the other hand, therapy for pulmonary or bronchial infection is instituted and attention is not directed toward the possibility of the presence of an underlying neoplasm, the opportunity for cure of a cancer may be lost. The most important responsibility for the finding and the successful treatment of bronchogenic carcinoma rests upon the first physician sought by the patient, therefore, and only rarely is this the thoracic surgeon who is called upon for the definitive diagnosis and treatment. An awareness of the frequency of this lesion and of the importance of the passage of time in persons with cancer really constitute the most important factors as regards the problem of early diagnosis in many cases of bronchogenic carcinoma. Whenever respiratory symptoms are important enough to the patient to cause him to seek professional advice, they should be considered gravely by the physician.

The roentgenographic and the "routine" fluoroscopic examination of the chest are at present the most valuable screening devices available to the average practicing physician in the finding of lung cancer. The presence of almost any abnormal shadow in the lung field,

in a patient in the cancer age group, should raise the question of carcinoma in the mind of the physician. Inflammatory lesions of various types may often be difficult to distinguish from neoplastic disease. Areas of pneumonitis or of atelectasis may be primary or they may occur concomitantly with or secondary to a neoplasm. A nodule in the periphery of the lung may be inflammatory or neoplastic. The differentiation of carcinoma from the purely inflammatory lesions often requires all the methods of investigation available, including bronchoscopy, examination of smears of the sputum by an expert cytologist and even exploratory operation.

The correct diagnosis may be ascertained with difficulty even at the time of operation. Chronic inflammatory lesions may be very firm, nodular and indistinguishable grossly from neoplasms, particularly when they are located deep in the substance of the pulmonary parenchyma. Furthermore, in many instances carcinoma is associated with extensive inflammatory changes. The incision of these tumors in situ for biopsy is undesirable and dangerous because of the risk of the implantation of tumor cells upon the pleural surfaces. Furthermore, the finding of inflammatory changes alone does not of itself rule out the possibility of the presence of cancer within the tumor mass. Radical pneumonectomy is, therefore, sometimes justifiable when the lesion is thought, but not proven, to be cancer.

The inflammatory masses which are apt to be most confusing are nodular or atypical tuberculous lesions and the lipoid granuloma of exogenous origin. The latter has been observed by us with increasing frequency during recent years. We have operated upon eight patients during the past five years in whom disabling symptoms have been produced by extensive granulomatous lesions which are believed to have resulted from the repeated ingestion of mineral oil. All of these patients were adults, ranging in age from 36 to 72, who were actively engaged in useful occupations prior to the onset of pulmonary symptoms. None exhibited evidences of cardiospasm, anatomical or neurological defects or any significant disease other than the pulmonary

lesions. All had taken mineral oil as a laxative with regularity over long periods of time and always at bedtime. In all, nodular tumors were found at operation which were associated with hilar and often mediastinal lymph node enlargement and which simulated carcinoma so closely that pneumonectomy was performed in five.

In most cases, on the other hand, the diagnosis of cancer can be made with confidence either prior to or at the time of operation. In most instances where grave question exists regarding the true nature of pulmonary lesions, extirpation of the lesion is justifiable and, indeed, is indicated. The risk of operation is now small in the hands of an experienced and careful operating team. The risk of delay may be many times greater in patients who have evidences of pulmonary nodules, atelectasis, "unresolved pneumonia" or hilar shadows of unknown composition whether or not there are associated symptoms.

In addition to the "tuberculomas" and the parafinoma, non-specific granulomatous lesions of pyogenic etiology are encountered occasionally and the various fungus infections may at times be confused with pulmonary carcinoma. The former represent the residual of bacterial infections which a few years ago would have resulted in the necrosis of pulmonary tissue and the formation of one or more abscesses in the lung. The failure of complete resolution of these areas of infection may result from inadequate antibiotic therapy or the presence of micro-organisms which are resistant to therapy and which remain viable and often dormant in

the tissues. These lesions often appear as single or multiple nodules of irregular outline and small cavities, surrounded by thick scar and granulation tissue, may be present. They may give rise to symptoms such as malaise, cough and the occasional production of muco-purulent sputum or blood-streaked sputum. They represent a potential hazard to the patient and should, in many cases, be excised. Their removal is certainly urgently indicated in patients of advanced age.

The fungus infections, such as histoplasmosis, coccidioidomycosis, blastomycosis and actinomycosis are less apt to be confusing as regards the differential diagnosis of lung cancer. Except for histoplasmosis, which usually is seen as a healed calcified lesion in the adult of advanced age, these infections are not encountered commonly. The symptomatology of bronchiectasis or of sarcoidosis, the effects of these diseases upon the patient and the distribution of the lesions usually make them easily distinguishable from malignant tumors, except when bronchiectasis is associated with atelectasis in patients in the older age groups.

SUMMARY

1. The differential diagnosis of carcinoma of the lung is discussed.
2. The responsibility of practicing physicians for the early diagnosis of pulmonary cancer is emphasized.
3. The importance of the "routine" x-ray film and fluoroscopic examination in the finding of early, and often of asymptomatic pulmonary carcinoma, is discussed.

Non-Tuberculous Diseases of the Chest; Pediatric Aspects

RICHARD W. BLUMBERG, M. D.

Department of Pediatrics, Emory University School of Medicine
Emory University, Georgia

Diseases of the chest have always been responsible for a high morbidity and mortality rate in children. With the advent of anti-microbial therapy there has been a marked decline in both rates but pulmonary disease still constitutes one of the more important present day problems. Perhaps the most striking observation is that the current problems are not the same ones that were important as recently as ten or fifteen years ago.

Pneumonia, whether bacterial or viral, no longer is regarded with fear. With the introduction of various antibiotics it has come under control and its complications such as empyema and abscess no longer fill the hospital wards. With the general application of immunization procedures, severe pertussis has nearly faded from the medical scene and its complications, such as bronchiectasis, are seldom seen. With the improvement of anaesthesia, control of infection and better knowledge of children, surgical daring has known almost no bounds in the past ten years as far as correction of surgical conditions of the chest is concerned. In spite of all this progress, there are certain pulmonary diseases which are still not amenable to drug therapy or surgery and which plague the pediatrician because they are so common. A few of these conditions will be discussed.

1. "Hyaline Membrane" Disease

While this is not a new disease, it has come in recent years to be one of the commonest causes of death in live born infants: in part due to the great reduction in neonatal mortality from other causes.

Characteristically infants with this disease are either prematures weighing from 1000 gms. to 2500 gms. or else term infants delivered by cesarian section. The infants usually breathe well after birth and for several hours may appear to be normal. Soon dyspnoea with

progressive cyanosis develops and respiration becomes labored. As the breathing becomes more labored, there is retraction of the sternum and lower ribs on inspiration. Breath sounds gradually become detectable with difficulty. Death usually occurs in the first 24 hours of life as a result of anoxia and exhaustion.

On post mortem examination, the lung of the infants appear dark red-purple. Histologic examination reveals wide-spread resorption of air and the walls of many alveolar ducts and most of the alveoli are collapsed. Intense capillary engorgement is responsible for the color of the lungs and their increase in weight. The inner surfaces of the alveolar ducts that remain expanded are covered by an irregular layer of homogeneous acidophilic material. It is believed that this material or "membrane" forms a mechanical barrier to normal respiratory exchange by blocking off some portions of pulmonary tissue and by coating the remainder in such a way that the capillaries are deprived of contact with oxygen-containing atmosphere.^{1, 2} A similar picture is almost never seen in still born infants, in infants who die within one hour of birth or in those who survive more than one week.¹

At the present time, there is no agreement as to the origin of these membranes. The two theories which are currently most popular concerning their origin are that they are derived (1) from aspirated amniotic fluid, or (2) from protein derived from the blood.

Treatment of the condition is quite unsatisfactory and should consist primarily of the following prophylactic measures (1) avoiding needless cesarian sections, (2) avoiding laryngoscopic procedures carried out by unskilled operators, (3) adequate drainage of the infant's upper respiratory tract immediately following delivery, (4) omission of feedings during the period of respiratory difficulty, (5)

the administration of antibiotics, and (6) use of oxygen-mists immediately following delivery.⁶

2. Acute Bronchiolitis

While antibiotics and sulfonamides have greatly reduced the number of deaths from the common forms of bronchopneumonia in infants and children, there is one type which remains unresponsive to the usual methods of treatment and which has been termed acute bronchiolitis. The disease deserves particular attention because its proper treatment is different from that of pneumonia and in our experience now represents the most common type of respiratory infection in infants requiring hospitalization.

Acute bronchiolitis occurs most frequently in infants 3 to 18 months of age. A history is usually obtained of the infant having previously had a cold followed by the sudden onset of alarming symptoms. The syndrome is characterized by rapid, labored respirations at a rate generally between 80 and 100 per minute. Respirations are shallow and usually accompanied by persistent cough and some cyanosis. Retraction of the soft tissues of the supraclavicular, subcostal and intercostal spaces is present.

On physical examination the chest appears emphysematous and is hyperresonant to percussion. The breath sounds are usually diminished in intensity during inspiration and prolonged during expiration. Audible wheezing is heard in about half of the patients. Fine crepitant dry rales are usually heard throughout the chest at the end of inspiration. The liver and spleen are often palpable due to downward displacement of the diaphragm by the emphysematous lungs.

Fever is not constant but varies from none to a temperature of 108°. When present, it may persist for a week or more.

The white blood cell count is usually normal or slightly elevated. Cultures from the nasopharynx and throat yield the usual organisms. Roentgenograms of the chest characteristically demonstrate emphysema and occasionally show small patchy areas of consolidation close to the hila and towards the bases.

The basic pathologic process is inflammation of the entire thickness of the walls of the bron-

chioles, with a spread of the inflammatory reaction to the interstitial tissues around the bronchioles, blood vessels and lymphatics and into the walls of the adjacent alveoli.

The course in untreated or poorly treated cases is marked by increasingly severe obstructive emphysema, anoxia, and exhaustion.

Treatment consists of attacking the infection, the respiratory distress and the oxygen lack.

Since a variety of organisms may be responsible a broad spectrum antibiotic is probably preferable. Most marked relief seems to follow the use of oxygen in conjunction with a mechanical humidifier. The cool moist air apparently aids in liquefying the bronchiolar secretions and preventing crust formation. Various antispasmodics are of only occasional value. Sedatives should not be used since maximal respiratory effort is needed to maintain life. Recently ACTH has been reported to be of value but we have not been impressed with its use.

3. Fungus Diseases of the Chest

While antimicrobial agents have done much to reduce the severity and complications of most bacterial lung infections, they have left in their wake a predisposition to certain fungus infections—primarily monilia. Likewise, they have been of no value with certain other fungus infections such as histoplasmosis and coccidioidomycosis.

While monilia has been most troublesome in causing esophagitis and laryngotracheitis, pulmonary infections with the yeast are also seen. The history of long continued antibiotic therapy and the appearance of the typical mouth lesions should make one suspicious that the monilia is the cause of the lung infection when widespread chronic lung disease occurs. Radiologic examination of the chest reveals a picture similar to miliary tuberculosis. Emphasis should be placed on prevention as treatment is most unsatisfactory.

Histoplasmosis is generally not a great problem in this part of the country and perhaps its primary significance is its ability to become confused with the picture of tuberculosis or other diseases. Pneumonic processes which do not readily resolve or respond to therapy particularly in the presence of a negative

tuberculin reaction, should make one suspect infection with histoplasma. Recently numerous "epidemics" of histoplasmosis have been reported. They have occurred in a high percentage of individuals who were engaged in work in a confined area, such as pigeon lofts, caves or silos. The immediate reaction is that of widespread pneumonitis ultimately resulting in miliary calcification.

There is no satisfactory therapy available for this infection.

4. Aspiration of Foreign Bodies

In spite of the progress made in the treatment of many diseases, children have changed very little and therefore continue to aspirate foreign materials.

A high index of suspicion of foreign body aspiration should be maintained with children who have chronic lung disease of obscure etiology. The frequency of involvement of the right lower lobe still holds and is further suggestive. Direct questioning regarding strangling or coughing episodes while eating will oftentimes recall to the family a possible source for the foreign material.

Probably the most common cause of aspiration pneumonia in Georgia is the ingestion of kerosene and other petroleum products. Characteristically a child between the age of 1 and 3 years drinks kerosene which usually has been left in a coca-cola or milk bottle. Only very small amounts are necessary to produce widespread lung involvement. Kerosene itself is practically tasteless but as the children swal-

low it irritates their throats, causing gagging and aspiration. Within 30 minutes to 1 hour after aspiration, wide-spread areas of consolidation can be demonstrated by radiologic examination of the lungs. There is considerable evidence to suggest that the pneumonia is a result of aspiration and not due to absorption and excretion of the material by way of the lungs. This fact becomes important in the management of these patients. Since gastric washing is likely to produce vomiting, coughing and further aspiration, this procedure is not carried out unless one has reason to believe a fairly large quantity has been ingested. Small amounts are left in the stomach.

Prophylactic drug therapy is given and the child kept under an oxygen tent until the pneumonia disappears and respirations become less rapid. Long term follow-up has revealed very little or no permanent damage but death may occur.

REFERENCES

1. Potter, E. L.: Pathology of the Fetus and Newborn. The Year Book Publishers, Inc., 1952.
2. Miller, H. C. and Jennison, M. H.: Study of Pulmonary Hyaline-like Material in 4117 Consecutive Births: Incidence, Pathogenesis and Diagnosis. Pediatrics, 5:7, 1950.
3. Traisman, H. S. and Bigler, J. A.: Bronchiolitis. Quart. Bull. Northwestern Univ. Med. School, 27: 313-315, 1953.
4. Henderson, A. T.: Bronchiolitis in Infancy: Clinical Study with Special Emphasis on Cardiac Complications. U. S. Armed Forces Med. J., 2:943-952, June, 1951.
5. Pratt, E. L.: Symposium on specific methods of treatment; acute bronchiolitis in infants, M. Clin. North America, 28:1098-1107, Sept., 1944.
6. Report of the Fifth M & R Pediatric Research Conference, Pulmonary Hyaline Membranes, 1953.

X-Ray Diagnosis of Pulmonary Neoplasms

HAROLD PETTIT, M. D.

Charleston, S. C.

There was once a time when the chief concern of a radiologist while reviewing a chest film was the possibility of overlooking a minimal or incipient tuberculosis. Considerable harm could, and still can be done by such an error, but with the increase in the incidence of bronchogenic carcinoma we have an added responsibility of greater difficulty. Few cases of bronchogenic carcinoma are cur-

able when discovered. If they can be uncovered before they have reached the symptomatic stage the possibility of surgical cure is greatly increased. It is the duty of the radiologist to maintain an active suspicion when any abnormality in the lung fields is encountered. On the other hand he must try to maintain a sense of balance. An overzealous examiner can find something to worry about

in almost every chest film. Three of four bronchogenic carcinomas arise in the major bronchi, and the first signs that they will produce will be secondary ones, those due to partial obstruction of the bronchus. The tumor itself will not be visible. First there will be a slight increase in the density of a segment of the lung. This is due to the decrease in aeration of this segment, lessened alveolar pressure and so an increase in the blood volume. This is a finding that is most often seen in retrospect when it does the patient the least good. Next in sequence is emphysema of the segment. This is another nebulous manifestation, and one to which little attention is likely to be paid unless there are confirmatory symptoms. When all of the lungs are fully expanded, as in the routine chest film, this is likely to be completely obscured. It is best seen on films made in full expiration or on fluoroscopy. These procedures are rarely done in asymptomatic patients, so the chances of discovering a carcinoma at this stage are poor.

The next change is due to a more complete blocking of the bronchus. Here is where the radiologist has a real chance to be of service and he must not miss it. The obstruction is sufficient to produce a partial atelectasis, or by retention of secretions, a secondary infection. The infection may clear under appropriate therapy, but rarely completely. There will be residual poor aeration and contraction of the lung segment. We have long insisted that all patients with consolidation of the lung be followed until there is complete resolution of the process, but have found that this is difficult to obtain, even with service patients. Too often a patient is seen with what is clinically and roentgenologically an ordinary pneumonia, he responds satisfactorily to therapy, is dismissed with incomplete resolution of the consolidation, and returns weeks or months later with obvious carcinoma, the lesion that has precipitated the original infection.

While the survey PA film of the chest has suggested the presence of many of these early asymptomatic lesions and the most elaborate radiographic studies have failed to reveal some with hemoptysis, positive cytological smears and metastases, the PA chest film is only a good start in case finding, and it is completely

inadequate when there is clinical suspicion of pulmonary disease.

The ideal chest examination would include preliminary fluoroscopy, with careful evaluation of aeration of all parts of the lung in every phase of respiration. We routinely examine the esophagus of every patient we examine by fluoroscopy. By doing this we have found achalasia, esophageal diverticula and carcinoma that have explained otherwise puzzling lung findings. Films in both inspiration and expiration are valuable in demonstrating the minor degrees of obstructive emphysema. Lateral and oblique films of the chest may expose beautifully lesions that are totally obscured by the hila or mediastinal structures on the PA film. A heavily penetrated Bucky film of the chest is also profitable in many cases, particularly when there is infiltration of the chest wall and bone invasion. It is obviously not economically feasible to do this on every patient, but it is advisable in cases of ill defined and obscure pulmonary disease. Bronchography and angiocardigraphy are more formidable procedures and ones requiring definite indications.

The signs of bronchial obstruction that I have mentioned are the early signs of the majority of bronchogenic carcinomas. They may be produced by inflammatory lesions of the bronchi and by compression of a bronchus by adenopathy, mediastinal tumor or aneurysm. These lesions must all be considered, but differentiation may be impossible short of surgical exploration.

The peripheral tumor is the one most likely to be uncovered in a routine survey. Unless it is subpleural it is less likely to produce symptoms and it is more easily seen as it is surrounded by aerated lung. These lesions can be and are mistaken for every possible lung disorder. A positive roentgenological diagnosis can rarely be made. There has been much ado by the surgeons over the delay between the demonstration of an abnormal lung shadow and exploration. They are perfectly justified in decriing delays of weeks and months while the progress of the lesion is being charted by x-ray after x-ray, but they must not object to a delay of two or three weeks during which time many of the suspicious lesions they never

see undergo complete resolution.

Not all peripheral tumors are circumscribed; their edges may be ill defined due to infection in the neighboring lung or to extension and lymphatic invasion. However, a rounded mass in the lung of an adult will in the majority of cases prove to be malignant. There was once a time that we could feel secure by demonstrating the presence of calcification in such a mass. We would assume that we were dealing with a tuberculoma, hamartoma, chondroma, or a dermoid. Recently too many partially calcified adenomas have been reported, and we cannot lightly dismiss these solitary masses on this basis today. Another possibility is necrosis of the center of the tumor, producing an appearance identical with that of a pyogenic abscess. Several of the fungus diseases may mimic carcinoma of the lung parenchyma, but sputum and skin studies and clinical investigation generally establish the diagnosis before surgery. Congenital cysts, hydatid cysts and sequestration of the lung may be impossible to identify.

Near the hilum we encounter myriad lesions that may be extremely difficult to classify. Hilar and mediastinal adenopathy may be due to tuberculosis, sarcoidosis, lymphoma or metastatic carcinoma, and one indistinguishable from the other radiographically.

Neurofibromas most often arise in the posterior mediastinum, but they may spring from the intercostal nerves at any point. Even when we can make a probable diagnosis of neurofibroma there is no way we can assure the patient that it is not malignant. The same is true of dermoids which are my favorite tumors because they so often exhibit an

identifying feature. One may contain a tooth or it may have sufficient fat to produce a zone of light density in the upper pole of the rounded mass. Some patients will obligingly cough up hair to establish the diagnosis. Other tumors are lipomas, fibromas, chondromas, ganglioneuromas and sarcomas. The final diagnosis rests with the pathologist, but any of the benign tumors may suddenly display malignant features, and the radiologist has done his part when he has demonstrated the presence and location of such tumors. Meningoceles sometimes produce large cystic intrathoracic masses, but the true nature may be indicated by vertebral deformities and confirmed by myelograms.

Aneurysms are all too often more perplexing. Cysts and even solid tumors may seem more intimately connected with the aorta and pulsate more than most aneurysms. By pressure on a bronchus an aneurysm may produce a partial or complete block and all the secondary signs of such a block in the lung. Angiocardiography has been of sizable help with this problem but occasionally the aneurysm will be so filled with clot or the neck will be so small that an inadequate amount of the opaque material enters the aneurysm.

The radiologist who looks for and heeds the early roentgenological signs of bronchogenic carcinoma will cause varying degrees of inconvenience to many well patients, and perhaps the physician will feel embarrassed for having urged the patient to undergo extensive examinations which reveal no abnormality. But this attitude will have to be adopted if a significant improvement is to be made in the cure rate of intrathoracic tumors.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

J. P. Cain ----- Mullins
J. D. Guess ----- Greenville
C. J. Milling ----- Columbia
H. R. Pratt-Thomas ----- Charleston

EDITORIAL BOARD
Vince Moseley ----- Charleston
Ben Miller ----- Columbia
W. H. Prioleau ----- Charleston

G. D. Johnson ----- Spartanburg
R. M. Pollitzer ----- Greenville
Hugh Smith ----- Greenville
Walter Mead ----- Florence

BUSINESS MANAGER: Mrs. C. G. Watson ----- 105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) ----- Charleston, S. C.
Subscription Price ----- \$3.00 a Year

JULY, 1954

Gamma Globulin in Poliomyelitis Prevention and Modification — 1954

Much has been said and written about gamma globulin use in poliomyelitis in 1953 and its effectiveness in the prevention and modification of the severity of paralysis. Its use in 1953 was in household contacts of cases of poliomyelitis and in mass administration to children from one to ten years in areas experiencing a high attack rate of acute poliomyelitis. The very elaborate, detailed, and meticulous analysis by the Evaluation Committee of the volume of data collected from the whole country of the use of gamma globulin in the ways mentioned revealed that gamma globulin as used as in 1953 did not prevent paralytic poliomyelitis and did not affect the severity of paralysis in cases subsequent to the initial case.

The analyses of the data in 1953 indicate that the administration of gamma globulin to familial contacts of patients with poliomyelitis had no significant influence on:

1. The severity of paralysis developing in subsequent cases.
2. The proportion of non-paralytic poliomyelitis among the subsequent cases who received gamma globulin before onset.
3. The classical pattern of familial aggregation of cases in the county at large.

Multiple cases occur in 3 to 5% of households. On the average, 60% of subsequent cases occur within the first five days of the first case, 30% within six to twelve days, and 10% in thirteen to thirty days. Even in a moderate epidemic year in South Carolina, secondary cases are relatively rare.

Mass injection of gamma globulin was carried out in 23 communities in the United

States in 1953. Children one to ten years of age were the usual recipients.

Analyses of extensive data on the use of gamma globulin in these epidemic areas and populations "did not yield statistically measurable results. Therefore, its preventive effect in community prophylaxis as practiced in 1953 has not been demonstrated. Also, no modification of the severity of paralysis by gamma globulin was shown." Usually by the time the gamma globulin could be given, the epidemic had passed its peak of occurrence.

The Committee did not say that gamma globulin produces no effect. With our present unsatisfactory methods of diagnosing mild poliomyelitis, our totally inadequate means of predicting in advance the location and time of an epidemic, and the difficulties of administering gamma globulin, its effective use in difficult if not impossible at the present time.

Gamma globulin will therefore not be distributed in 1954 for household contacts. On the recommendation of the Infectious Disease Committee of the State and Territorial Health Officers and the Advisory Committee of the NFIP, gamma globulin will be distributed in 1954 only for use in groups larger than the household, such as, an entire apartment building, a play school, housing project area, city block, camp, rural community, etc. In South Carolina in 1954, it will be distributed as follows:

If the County Health Officer believes the incidence of poliomyelitis suggests or requires the administration of gamma globulin to all persons of a particular age group in such geographic or social area, as stated above, he may, with the approval of

the State Health Officer, request sufficient gamma globulin to distribute to physicians for the inoculation of the entire group.

Gamma globulin will be available for pregnant women who are contacts of poliomyelitis cases.

Gamma globulin will not be available in counties participating in the vaccine field trials except when in the opinion of the State Health Officer, and with the advice of the Poliomyelitis Advisory Committee, such use would not affect the validity of the field trial of the vaccine.

While the following is primarily of local Charleston interest, we believe that many of our members over the state will be interested in the several institutions concerned. It is in no way controversial, and simply sets forth certain problems which must be met to the mutual advantage of all parties concerned.

The Editor

**A Challenge and An Opportunity Face
Charleston Community Medicine Upon
The Opening Of The Medical College
Hospital**

The opening of the Medical College Teaching Hospital presents both a challenge and an opportunity to the Roper Hospital in particular and to the Charleston community in general. The challenge is to the Roper Hospital to continue to offer to the community the services of a fully accredited hospital, and to the community to support it in its effort to do so. The opportunity is for the Roper Hospital to retain its close working relationship with the Medical College thus making it possible for it to continue to provide facilities of a kind and an extent not commonly found in a hospital of a community of this size. The Roper Hospital is now, and has been for many years, the teaching hospital for the Medical College. As such the Roper Hospital has benefitted by being accredited by the various examining bodies, thus enabling it to obtain professional staffing and certain services of a type required of a first class hospital.

With the opening of its own hospital the

Medical College will no longer be dependent upon the Roper Hospital; however the present plan is for the two institutions to continue their close working relationship, which should be to their mutual advantage. The Medical College Hospital will serve the state as a special hospital for certain types of cases of particular value in teaching and for the study of medical problems. The Roper Hospital will continue to serve as the community hospital. Both fields are essential to a well founded teaching program. The Roper Hospital will benefit by having on its attending staff members of the College faculty, by being approved for the training of interns and residents in the various specialties, and by having available to it the laboratories of the teaching institution. The Medical College will benefit by having available to it for teaching purposes beds in the Roper Hospital. This will be of particular value because a community hospital such as the Roper has patients with acute, traumatic and contagious diseases not commonly found in a college hospital. To the advantage of both institutions, economies should be effected by avoiding unnecessary duplications in both the professional and administrative fields.

In order for the Roper Hospital to enjoy to the fullest extent the advantages of a close working relationship with the Medical College, it is necessary that it provide hospital beds which are of particular value to the Medical College for teaching purposes. This is going to present a problem. At present, as the teaching hospital for the Medical College, the Roper Hospital is now caring for State and Federal Agency cases. This group of cases will naturally be transferred to the Medical College Hospital which is a state institution. Deprived of the income from this block of cases it does not seem possible that the Roper Hospital can continue to operate the old building in which these patients are housed. There would be left in this building the county indigent cases and a few private cases, the income from which would be insufficient to operate it in a satisfactory manner. Should it be necessary to close it, the loss of the county indigent patients would deprive the Roper of an asset of tremendous teaching value to the Medical College.

The old building is obsolete from many standpoints. Working conditions in it are such that it is difficult to keep it properly staffed. It is unacceptable to patients who have any other choice. Its administration and maintenance are much more costly than of a modern building. To remodel it would remove many of the objectional features; however the result would be unsatisfactory as it is so far removed from the new building that it could not be integrated with it so as to avoid costly duplication in administration and staffing, and some supply and treatment facilities.

To replace the old building the Roper Hospital is in need of an addition to its new building to permit it to care for the county indigent cases in an efficient and economical manner. In such an addition provision could be made for a department in which colored physicians could have adequate hospital facilities, a most urgent need. There could be established a training school for colored nurses. This would be of great value in relieving the shortage of nurses in this section. The Roper Hospital is not able to finance this much needed addition. The income of the Roper Hospital consists of receipts from private pay patients, \$20,000.00 interest from endowments, an appropriation from the county for the care of the indigent sick, and, until the opening of the Medical College Hospital, receipts from state and federal agency cases. It is operated as a non-profit institution by the Medical Society of South Carolina. It is able to finance the construction of additional beds in the private pay department which is self supporting; however its assets are too limited to permit it to borrow for a building program sufficient to fill the greater needs of the community.

It would be to the advantage of Charleston County to assist the Roper Hospital in a building program designed to meet the more pressing needs of the community. This would permit the Roper Hospital to continue to care for the county indigent, would provide hospital

facilities for colored physicians so necessary for the proper care of their patients, and would do much to assure that the Roper Hospital continue to provide adequate first class hospital facilities for the community. The county would have to assist in the financing of the proposed addition; however it would be relieved of the administration and staffing which would be assumed by the Roper Hospital and the Medical College.

Should Roper Hospital be forced to close the old building without having an adequate replacement for it, the county would be faced with the problem of caring for the indigent. Building a separate hospital for the purpose would be accompanied by difficulties of administration and staffing. There would be the problem of an Emergency Department. There would remain the problem of providing hospital facilities for colored physicians in the care of their patients.

In such case the Roper Hospital would be essentially a hospital for private patients and do such charity work as income from endowment permitted. In this limited field it would continue to operate upon a high standard. It would endeavor to maintain as close as possible a working relationship with the Medical College; however in this respect it would be seriously handicapped by its restricted field of activity and in particular by the loss of the county indigent patients which are of inestimable value from the teaching standpoint, and in training of interns and residents.

It would be to the advantage of the Roper Hospital, the Medical College and the community in general to have the medical facilities of the county centered in the Roper Hospital, in great part on account of its close working relationship with the Medical College. This would be of great value in the development of Charleston as a medical center. It is hoped that a way can be found to make this financially possible.

W. H. Prioleau, M. D.

PRESIDENT'S PAGE

I should like to take this opportunity to greet each member of the Association and to ask your support in the coming year. Any suggestions or criticism as to the conduct of the affairs of the Association will be welcomed.

Committee appointments are being studied and will be announced within a short time. As most of you know, the Association will meet next year in Charleston and a committee from Council is now considering what dates will be most appropriate.

It is my plan to accept invitations as far as possible from any County or District Association anywhere in the State, barring conflicts.

• • • • •

Last week the House Ways and Means Committee included in the new Social Security Bill a provision for compulsory inclusion of physicians. After this was brought to the attention of the doctors of the country, there was a deluge of telegrams and letters opposing this. As results the Committee reversed itself and removed physicians from the list. It is hoped that the profession will continue to watch developments in Congress and let its views be known on matters affecting its welfare.

• • • • •

South Carolina will have a good representation at the A. M. A. meeting in San Francisco with a Trustee, two delegates, two alternates, the President and Secretary, Dr. Buck Pressley, and possibly one or two others.

Fraternally.

Tom Gaines

REPORT FOR CANCER CONTROL FOR STATE OF SOUTH CAROLINA—1953

In the writing of the report for Cancer Control Commission of South Carolina, the writer thought it would be appropriate to use a recent article delivered by Dr. J. R. Young, Chairman of Cancer Control Commission. It is felt that this is an excellent treatise which gives the reasons and functions of cancer clinics and the philosophy upon which this important service is based.

John M. Fleming, M. D.

The following is the body of Dr. Young's address:

It has been my good fortune to have witnessed the marvelous changes that have come about in surgery for about half a century. Beginning in the horse and buggy days, before hospital facilities were available in my town, we operated on the kitchen table by the light of the kerosene lamp. I am sure I could relate an interesting tale from those horse and buggy days up to this good year of 1954, but after the tales were told no one would be any better prepared for the problems that confront us today. Therefore our eyes and thoughts will not be turned backward, but to the current problems of today and the future. In the background of all that I shall have to say there will be the thought of the changed rating which the average Mr. Citizen has of the present day doctor, as compared to his appraisal of the doctor in the horse and buggy days. We sometimes embellish the story of our immediate professional forebears with not a little tradition that may be more romantic than it is factual. We ascribe to them credit for having first developed in the minds and hearts of their contemporaries a very high esteem for the members of our profession. This is by no means true. History teaches that this high degree of esteem and affection which we may enjoy has been shown by many people for many centuries. Its fervor has shown something of a pendulum-like regression and resurgence. In the book of Ecclesiastes, which is one of the books of the Apocrypha and was written some two hundred years before the birth of Christ, we find an author by the name of Jeshua giving voice to this arresting poem:

"Honour the physician with the honour due unto him;
For verily the Lord hath created him;
For from the Most High cometh healing;
And he shall be honoured even by the king;
The skill of the physician shall lift up his head;
And in the sight of great men he shall be exalted.
"The Lord created medicine out of the earth,
That He might be glorified in his marvelous works;
And he that is wise will not despise them.
With them doth the physician heal a man,
And taketh away his pain.
Yea, there is a time when in his hand is the issue of life;
For by his skill doth he make supplication unto the Lord;
That he may prosper him in giving relief
And send healing for the maintenance of life.
And from him is peace upon the face of the earth."

We see from this beautiful poem that the affectionate esteem held for the physician of that day was very similar to that enjoyed by our more recent forebears. During the intervening centuries the varying changes in rating has been more quantitative than qualitative, and the flavor and fervor of this esteem in successive generations has largely varied in direct proportion to the skill and dedication of the physicians of each generation.

In the long ago a very picturesque statement was made by a vivid author; "So thou, O son of man, I have set thee a watchman unto the house of Israel; therefore thou shalt hear the word at my mouth." Please remember all through this talk that I am speaking to you as the watchman whom you selected and not as a private individual. Were I speaking in that capacity the personal pronoun would not be so much in evidence, nor would I speak for the Congress in the tone of one having authority.

The subject on which I wish to drape my thoughts is "The Value of a Cancer Clinic in a Community Hospital." In order that we may be sure we are thinking in the same terms some definition is necessary. By a Cancer Clinic we mean an organized group of doctors and associates selected from the staff of a hospital who, at a regular time and place, meet for the examination of patients who are thought to have cancer, and who further are prepared and equipped to treat those patients who are found to have this disease. An approved clinic must have efficient secretarial help, as well as a satisfactory follow-up system. The definition which I have in mind of a community hospital is one that is not a large teaching hospital, but is a hospital built after some acceptable pattern by the citizens of the community. The staff of the clinic must include at least a competent pathologist, a competent and equipped radiologist, and one or more surgeons trained to do radical cancer surgery. It is my opinion that a cancer clinic so manned and equipped is capable of rendering a very definite worthwhile service.

The first and very obvious value of such a cancer clinic is to the patients treated. It is undoubtedly true that many cancer patients can be brought to a local clinic who would not consent to go to a more distant hospital. We have been working in such a clinic in our hospital in Anderson for the past fourteen years, and we have seen many cases of cancer relieved that would certainly have died had not the facilities of this clinic been available. We have now on the rolls of our clinic 187 patients who have been cured, or in whom the disease appears to be under control. We have 196 other more recent patients, most of whom are making satisfactory progress. Of our cancer patients, 343 have died during this fourteen year period. During the last illness of most of these patients our field worker was able to render an appreciated service to the patient and family.

But probably an even greater value that the cancer clinic may render is in the field of education. It is certainly true that in most communities the composite

thought of its citizens is that cancer is usually rapidly fatal and that operation only hastens the fatal outcome. This opinion, inherited from countless generations seems now imbedded in the cellular protoplasm of mankind. To uproot or wholly loose such deeply ingrained opinion must necessarily be a gradual process. We believe that a well-conducted cancer clinic may serve as a valuable aid in accomplishing this end. Abstract teaching in regard to the curability of cancer, as contained in many available pamphlets, is not nearly so convincing to the average person as the living presence of a neighbor or acquaintance who has been relieved of cancer. By far the most effective sermon on the curability of cancer is preached from the reclaimed patient as a text. In this way the cancer clinic may serve as a catalytic agent in dissolving the superstition and wellnigh fatalistic attitude that is so widespread.

Another benefit which a cancer clinic such as outlined above may render in a community hospital is in keeping all the members of the staff alerted in regard to cancer. One or more times a year the entire hospital staff should have the benefit of reviewing the accumulating experience of the cancer clinic. At frequent staff meetings gross specimens and microscopic slides should be presented by the pathologist. A cancer clinic satisfactorily staffed and equipped and conducted as we have described may become the outstanding service unit in a community hospital. The service will extend not only to the patients of the clinic, but will very effectively and progressively serve the community as a warning or alerting agency, in regard to cancer. The value of the cancer clinic as a professional teaching agency will vary in direct proportion to the use of the clinic's consultation service by all the members of the hospital staff.

But all of us who conduct cancer clinics know that many, far too many, patients brought to the clinic are found to be hopeless as far as cure is concerned. While this is true, probably no department in the hospital is so strategically situated to impress the patient and his family that all the resources of the hospital are available to ameliorate his disease. These are the cases in which palliative surgery and x-ray therapy is oftentimes indicated and where hormones and other palliative therapeutic agents may be used to advantage. It is usually not possible, and probably not desirable, that the patient be kept in the hospital for long periods of time; but by careful follow-up care, frequent visits by the patient to the clinic and visits to the home by the field nurse, the patient will become convinced that the resources of the hospital are dedicated to his care, and a natural feeling of appreciation will follow. If the attitude of the cancer clinic patient and his family is not one of grateful appreciation, there is probably something wrong in the conduct of the clinic. It may be, however, that this debit item is due, not to the personnel of the clinic itself, but to an unfriendly climate that prevails in the hospital where the clinic is situated. We know of no reason why the personnel of the hospital should be unfriendly

or lacking in the sympathy for the cancer clinic patient. In our state the Cancer Division of the State Board of Health makes satisfactory financial arrangements with the hospitals where the clinics are situated. Truth compels us to say that the lack of the friendly climate may be due to the members of our own profession more than it is to other members of the hospital personnel. This disapproval, or neutral reaction to the activities of the cancer clinic on the part of some members of our profession, stems from the phobia which exists in the minds of some members of our own profession towards Socialized Medicine. We are well nigh unanimous in our opposition to this pattern of medical practice in our country, but there is a large difference of opinion as to the best method of preventing Socialized Medicine from becoming the accepted pattern of practice. After a half-century's experience of medicine, it is my humble opinion that the surest way of preventing this from ever happening would be for the doctors in each community to furnish competent medical care to all its citizens! This, of course, is a big order, but I believe it can be done. It cannot be done after the pattern of the horse and buggy days of seeing each patient in his home, but with good roads, easy transportation, and closely spaced hospitals, the health needs of our citizens can be satisfactorily met, provided the doctors cooperate and organize to supply this need. Now it has been found that cancer is such a major problem in our national life (one out of each five of us at the present incidence rate being destined to develop this disease) that it can best be handled by setting up clinics in connection with hospitals, where patients may be cared for regardless of their inability to pay for the service. The close cooperation between the state board of health, federal agencies and voluntary health agencies, such as the American Cancer Society through its divisions, have made it possible for cancer clinics to be established throughout our country. There are now in the southeastern part of the United States ninety two (92) such clinics that are rated as competent. I believe that each of these clinics is earnestly attempting to render a worthwhile service to its patients. A more widespread endorsement, support and use of these facilities by the medical profession would not only be in interest of the low-income patients themselves, but also would be a very eloquent demonstration to the public that the medical profession accepts the challenge of caring for medically indigent patients.

Now if a satisfactory job can be done in the very major problem of cancer, it would seem reasonable to suppose that all the health problems of our citizens might be met, were similar organized and determined efforts made to that end.

But the consultation service of the cancer clinic should be available, not only to the cancer clinic patient, but to every case of cancer that is admitted to the hospital and to every case that occurs in the area of the clinic. It is really in this class of private patients who are victims of cancer that the cancer clinic may

do its most valuable service in the realm of public relations. The pattern for rendering this service should be somewhat as follows: in order to increase the frequency and value of such consultation service the clinic staff should agree that the service is available at little cost; to many low income private patients we think no fee should be charged. When this service becomes routine, consultation will be somewhat as follows: on request from the physician in charge, the proper individual from the cancer clinic staff will conduct the consultation. He will become thoroughly familiar with the clinical findings of the case, and then he will see the patient with the physician, and himself make a careful appraisal of both the patient and his disease. Then, after a frank discussion, the clinic consultant will, as much as condition will warrant, congratulate the patient and his family upon the thorough way his physician has handled the case. It will always help the patient and his family to be told they have exercised good judgment in their selection of a private physician and such technique never offends the physician in charge. The consultant should then emphasize to the patient and his family the encouraging aspects of the case and then impress on them that the treatment advised is not only thought wise, but that it is the consensus of medical opinion of the world that this treatment is the best now available anywhere. When the clinic functions in this way, all the members of the hospital staff, together with the members of the cancer clinic staff, may confidently assure the patient that all resources of the hospital are at his command and that no effort will be spared. If such a climate or sympathetic atmosphere prevails during the stay in the hospital, it will serve very effectively as a shock-absorber when the time arrived for making financial settlement at the close of a hospital stay. Much of the present criticism of hospitals and doctors stems from this belief held by many people that we doctors send to the hospital many patients who might recover satisfactorily at home, and they further believe that the cost for this hospital and medical care is far too high. We will not argue too much as to the validity of this opinion held by so many. Suffice it to say that the increased cost of hospital care is due to very demonstrable causes; first, the increased cost of commodities and services which the hospital furnishes; second, the very marked increase in the scope and skill of services. While it is true that the annual income of physicians and surgeons has increased, as has the income of everybody else, most of the increase in the income of the surgeon has been due to the fact that more people have been able to pay his regular fee than in former years. There has been comparatively little change in the fee schedule for professional service in most communities.

However, it is true that in the proper care of a cancer patient, few would argue that home care is superior or equal to treatment that may be received in a well-equipped hospital. So there is usually no resentment on the part of the patient, or his family that the cancer patient was advised to go to the hospital. However, there is always some resentment on

the part of the average citizen against being sick at all. He has put little in his family budget for major illnesses, and many of the insurance policies that satisfactorily cover minor illnesses are entirely inadequate for the major cost of cancer treatment. It is therefore a very auspicious thing to have a pre-arranged, smoothly functioning shock-absorber available for the financial transaction. Nothing will serve so well in this capacity as a very definite impression on the part of the patient and his family that the entire resources of the hospital have been available for the physicians in charge of this case and that regardless of the amount of hospital bill, he has experienced value received. This quirk of human nature is an interesting thing to observe. The afferent dollar to the average person is a very insignificant coin—maybe about like the widow's proverbial mite. He thinks for the service he has rendered he should receive far more of the said coins. However, the efferent dollar, which may have remained in his possession only a short while, by some strange alchemy has enhanced in value and looks as big as a cart-wheel and, as he sees it depart, he cannot understand why a couple of them should not pay for almost any commodity or service. Now it could be that the members of our own profession have developed a slight touch of this malady! I believe it is undoubtedly true that no small proportion of the resentment that exists in the minds of many people towards the members of our profession is closely associated with the item of folding money. Nothing would come as near dispelling this belief as would the habitual effort of every doctor to follow the advice of Sir William Osler, to give every patient more than he charged them for. The human male, as well as female, is pleased to think that he received bargain-counter values. Was not at least part of the esteem and affection, and even veneration, given to the family physician of the old school due to the fact that the patient's family so often felt that they were getting in kindly service far more than they were paying for? And, between ourselves, it could have been that some of the second mile technique adopted by our illustrious forebears was due to the vicissitudes of travel, roads, and weather. Be that as it may, the fact remains that according to legend and letters doctors of the old school were more highly esteemed than are we. While the doctors of today may not use the same second-mile technique as did our forebears in the horse and buggy days, the same second mile principle might be very convincingly used by us now if we habitually follow the advice given by Osler. It should therefore, be the solemn duty of each one of us to remember that the financial transaction incident to the service we render our patients may be so conducted as to offend the sense of justice and fairness of the patient. And as a result the reputation of the entire profession suffers. Far be it from me to presume to offer an original formula for this procedure. However, I believe that the majority of the members of the South Carolina Medical Association have found that the open sesame to a mutually happy handling of this matter is always present when the advice of the Great

Physician, as summed up in the Golden Rule, is made to season this transaction. The physician who is a disciple of the Great Physician and uses this Golden Rule in dealing with his patients will not only endear himself to them but will do much—very much—in restoring to our profession esteem and affection of a grateful people.

Statistical Report of State-Aid Clinics of the State of South Carolina

During the calendar year of 1953, 1,115 new cases of cancer (436 males and 679 females—of which 670 were whites and 445 were negroes) received treatment in the 10 State-Aid Cancer Clinics. An additional 2,212 old cancer clinic patients were examined periodically in order that any recurrence of the disease could receive prompt consideration. These 3,327 persons with cancer made 12,111 visits to the clinics.

Since prompt treatment of the early case of cancer means cure in the majority of instances, we are always interested in arriving at the number of early cases treated in the clinics. In spite of extensive educational programs, the majority of the cases treated were advanced. Only 422 or 38% of the new cases of cancer treated during the year had localized disease. After eliminating the 219 persons with skin cancer from the compilations the 422 early cancer cases dwindles to 203 and the percentage of early cancer decreased from 38% to 23%. The 422 patients receiving treatment for early cancer consisted of 188 white females, 141 white males, 69 negro females and 24 negro males.

It is interesting to note the difference in Primary Cancer sites in the males and females receiving treatment in the State-Aid Cancer Clinics in 1953.

Below are listed the ten most common cancers treated in males and females showing total number of cases and number of localized cases.

MALES		
Type	Total	Localized
1. Skin	141	121
2. Respiratory System	44	7
3. Prostate	42	6
4. Buccal Cavity & Pharynx	39	14
5. Other Sites	29	2
6. Urinary Organs	21	3
7. Lymphosarcoma	21	2
8. Esophagus	20	1
9. Stomach	18	0
10. Colon	12	2
FEMALES		
Site	Total	Localized
1. Cervix	223	73
2. Breast	129	29
3. Skin	104	98
4. Buccal Cavity and Pharynx	40	18
5. Other Sites	28	3
6. Rectum	21	3
7. Ovary	21	4
8. Fundus of Uterus	17	9
9. Vulva	15	7
10. Stomach	14	2

The most frequent type of cancer receiving treatment in the State-Aid Cancer Clinics is cancer of the skin. Two hundred forty-five persons (228 whites and 17 negroes) were treated for skin cancer. Eighty-nine per cent of these persons had localized disease. The next most frequent type of cancer receiving treatment was cancer of the cervix. Two hundred twenty-three females with cancer of the cervix were placed under treatment. Since early cervical cancer is curable in 8 out of 10 cases it was disappointing that only 73 or 32.8% had cancer that had not extended beyond the cervix. With more and more physicians including speculum examinations of the cervix and cytological studies of cervical secretions in the routine examination of their female patients, it seems reasonable to expect, in the not too distant future, an increase in the number of early cases of cervical cancer discovered.

One hundred and twenty-nine females and one male with cancer of the breast were admitted to the cancer program. In only 29 (or 23%) cases was the cancer limited to the breast. The percentage of early cancer of the breast was slightly higher in white females than in colored females—that is, 24% as compared to 20%.

Cancer of the mouth and throat was the fourth most frequent type of cancer treated in the clinics. Although cancer of the oral cavity can be diagnosed early, many patients delay visiting their physicians until the cancer has become advanced with secondary growths in the lymph glands of the neck and elsewhere. It was, therefore, slightly stimulating to find that 32 or 40% of the cases of mouth and throat cancer were early cases.

The incidence of lung cancer is definitely on the increase. This type of malignancy is of mounting importance as a cause of male death in this state. Cancer of the lung was the second most common type of malignancy seen in males in the cancer clinics. Only 8 or 16% of the 50 cases seen were localized in the lung. This continues to be a very discouraging picture in spite of the fact that this section is putting more and more emphasis on the importance of chest X-Ray in discovering lung cancer in the early stage.

Gastro-intestinal cancer kills more South Carolinians than cancer of any other site. Significant symptoms are present only when the disease is advanced. Therefore, it was not surprising that 14 or 10% of the 114 cases of cancer of esophagus, stomach, colon and rectum were early cases. There were 32 cases of cancer of the kidneys, ureters or the urinary bladder treated. Five or 16% of these cases were early.

The facts and figures presented above relative to the number of early cases of cancer treated in the 10 State-Aid Cancer Clinics are distressing and discouraging. Nevertheless, it is well to remember that the lives of 422 indigent South Carolinians with cancer were probably saved as a result of the cancer control program during the calendar year of 1953. Many other cancer clinic patients, although not cured, have had their lives prolonged and made more comfortable.

New Activities For State Cancer Clinics Year 1953

Regulations were adopted and inspections were carried out on fluoroscopic shoe fitting machines used by commercial firms. These machines, if improperly constructed or improperly used, are a real and potential carcinogenic danger to operators and customers. Units producing excessive or unprotected X-Ray beams have been confiscated or renovated to correct these hazards. Mr. J. P. Carter, registered X-ray technician, is in charge of these inspections.

New Activities Begun This Year 1954

On February 3, 1954, the physicians connected with the Self Memorial Hospital at Greenwood made formal application to the State Board of Health to open a State-Aid Cancer Clinic in connection with the Self Memorial Hospital at Greenwood.

One of the State-Aid clinics received instructions and facilities for operating a Radio-Active Isotope Laboratory.

Your Cancer Commission, because of lack of funds, was unable to approve the opening of the above cancer clinic. If the State Board of Health receives funds being requested from the present State Legislature, your Cancer Commission will reconsider this application after July 1, 1954.

The Physician's Contribution

Almost daily, the physician is called upon to contribute of his time and talents for which his only remuneration is the satisfaction in helping mankind.

When Charleston county was selected for the poliomyelitis vaccine field trials, the physicians of Charleston volunteered their services to administer the three doses of the vaccine to the second grade school children free of charge. Sixty Charleston physicians volunteered for this work, and every one of the scheduled clinics were met promptly at the appointed hour.

Everyone has been hoping for an effective vaccine that will prevent paralytic poliomyelitis. The final test of a vaccine is its effectiveness in preventing the particular disease in nature. Whatever the results of these trials may be, progress will have been made, and Charleston physicians have contributed unselfishly to the conquest of another feared disease of mankind.

As your State Health Officer, I wish to sincerely thank the Charleston County Medical Society and those physicians who volunteered to administer the vaccine for their very great help. The job could not have been done without your help.

Ben F. Wymann, M. D.
State Health Officer

NUTRITION

IMPROVED DIETS AS A MEANS OF REDUCING MATERNAL DEATHS

South Carolina has done a great deal to improve the health of expectant mothers as shown by the decreased maternal death rate. In 1929 the mortality rate was 11.4 per 1,000 live births as compared with 1.74 in 1949 and 1.4 in 1952. Even so, much remains to be done. In 1949 (most recent figures available on national level), the national rate was .9 per 1,000 live births and only four states, Mississippi, Alabama, Georgia and Arkansas had higher rates than ours. In the light of newer knowledge of obstetrical practice and nutrition one way to reduce maternal morbidity and mortality is by improved diets for prenatal patients.

The two leading causes of maternal deaths in South Carolina are the toxemias and hemorrhages, both of which may be influenced by diet. Toxemias seem to occur more frequently among patients having poor diets, especially when the protein content is extremely low. Inadequate protein as well as high sodium upsets the osmotic balance in body tissue and permits an escape of fluid into the extracellular spaces causing edema.

Generally speaking, hemorrhages are more likely to occur among anemia patients and certainly the results are apt to be more disastrous when there is a low hemoglobin.

The State Board of Health Annual Report (1952-53) states that 68.9% of the white patients and 44.2% of the Negro patients attending prenatal clinics for the first time had hemoglobin readings below 75%. Anemia may not exist to this degree and extent among private patients but the problem does exist. No doubt improved diets would decrease the number of hemorrhages and the resulting casualties. The time factor of blood coagulation and the muscle tone of the body, both of which are influenced by diet, are also factors in hemorrhages.

An important part of prenatal care is instructing the patient what to eat, and approximately how much. If a patient is to control weight gain, it is highly important for her to know *what* to eat as well as what *not* to eat. The person giving the instruction, whether he be physician or nurse, should know something of the food habits of the patient and her family, and must have some knowledge of food values and food costs.

The Food and Nutrition Board of the National Research Council recommends for the pregnant woman 80 grams protein, 1.5 grams calcium, 12 milligrams iron, 6,000 units Vita-

min A, 200 milligrams riboflavin, 15 milligrams Niacin, 100 milligrams Vitamin C, and 400 units Vitamin D.

The suggested menu below will supply 100% or more of these nutrients except Vitamin D.

Suggested Menu Pattern and Protein Content

Milk—1 quart	32 Grams Protein
Lean Meat or fish—4 ounces	24 (Approx.) "
Fish	
Egg	6 Grams Protein
Dried Beans or peas—2/3 cup cooked	8 Grams Protein
3 Slices bread or equivalent in biscuits or cornbread	6 Grams Protein
1 Cup Grits or other cereal	3 Grams Protein
Collards or Turnip Greens—2/3 cup	4 Grams Protein
Tomatoes or some other good sources of ascorbic acid	1 Gram Protein
Sweet or Irish Potato	3 Grams Protein
Margarine or Butter	0
Sugar for coffee	0

87 Grams Protein

The menu above will provide approximately 87 grams protein and 1800 calories if whole milk is used and about 1500 if non-fat. Unless the calorie level is brought up to meet the energy needs of the patient the proteins will be used for fuel rather than for building and repair.

Patients who attempt to satisfy their food needs by the use of vitamin and mineral concentrates should be reminded that these are only food supplements as they supply only a limited number of vitamins and minerals and no protein or roughage and certainly add no pleasure to a meal. The cost is another important factor, especially with low income families.

Adequate food is essential to the health of the mother and the fetus and diet instruction is essential for good prenatal care.

BOOK REVIEWS

A MANUAL OF TROPICAL MEDICINE—Second Edition—by Thomas T. Mackie, M. D., Col., M. C., A.U.S. (Retired), George W. Hunter, III, Ph.D., Col., M.C.S., U.S.A., and C. Brooke Worth, M. D.—W. B. Saunders Co.—Philadelphia and London—Price \$12.00.

The authors of this book presented the first edition in the form of "A Military Manual", and it was widely accepted by both medical student and physician because of its practical approach to all phases of the disease under discussion. This new second edition embodies all the features of the first edition with expansion in numerous areas and in keeping with increased knowledge of disease. Presentation of the material in schematic form affords a quick outline of the material in each section.

The section on virus diseases has been greatly expanded and should be a most helpful ready-source of

information. The attention given to medically important arthropods is likewise a valuable section for the physician. The treatment suggested for each disease discussed is concise, the most accepted, and latest. For general medicine, this is probably the most concise and authoritative source for information in Tropical Medicine.

H. L. Schofield, Jr., M. D.

MAYO CLINIC DIET MANUAL: By The Committee on Dietetics of the Mayo Clinic. New, Second Edition. 247 pages. Philadelphia and London: W. B. Saunders Company, 1954. Price \$5.50.

This diet manual has practically every type of diet one would ever want to use, besides standard hospital diets, including the following: tube feeding; gastric surgery of all types; colostomy, ileostomy, or resection of bowel; operations on the lower part of intestinal tract; operations on the colon or vaginal hysterectomy, etc. There are diabetic diets; diets for obesity; diets for underweight; cardiorenal vascular diseases; iron deficiency anemia; food allergy; infants and children, etc. Then there are certain test diets, such as low calcium, high purine, etc.

It is a very good reference book for dietitians or doctors. I do not think that it is the type of book that would be suitable to hand to one's office nurse or secretary, asking her to copy a diet to give to a patient. I think it would be confusing to a patient to find "dialyzed milk" on his low sodium diet list, or "cooked refined corn, rice, and wheat cereals" on the ulcer diet list, for example.

I was surprised to note the following:

(1) Spices, vinegar, and gravy on soft and bland diets. These might be used with discretion in the hospital, but it does not seem a good idea to leave it to a patient's judgment for home use.

(2) Ham on a gall bladder diet. Usually no pork is given on a low fat diet.

(3) Syrup on the prenatal diet. Many of these patients have to watch their weight. Molasses and brown sugar are superior in food value to syrup, if sweets are allowed.

(4) No dried fruits are allowed on diabetic diets. This is in disagreement with diabetic diets sponsored by the American Diabetes Association and American Dietetic Association.

A person with good knowledge of nutrition and diet would find this manual quite useful. Often, as with most diet manuals, it would have to be modified to be suitable for local use.

Margaret Freeman, Dietitian

THE HEPATIC CIRCULATION AND PORTAL HYPERTENSION, by Charles G. Child, III, M. D., W. B. Saunders Company, Philadelphia, 1954. Price \$12.00.

This is no book for the casual reader. It recounts in full detail all our present knowledge of the blood supply of the liver and its clinical implications. The illustrations are numerous, well-chosen, and to the point. The forty-five page bibliography covers the recent literature in comprehensive fashion and the index is adequate.

The basic anatomy and physiology of the hepatic vasculature is described at length with full discussion of the observations and interpretations of other investigators in this complex field. The chapters on the extra-hepatic splanchnic circulation and on portal hypertension contain much of interest to the clinician concerned with liver diseases.

The author's own extensive experimental and clinical studies are summarized in the appendix. He is a pioneer in showing the possibility of resecting the portal vein in certain operations for cancer. The doctor who can read through and understand this book will have had a post-graduate course on the portal

circulation. It should be on the shelf of every internist and surgeon interested in the liver.

F. E. Kredel, M. D.

MANUAL OF CLINICAL MYCOLOGY, by Norman F. Conant, Ph.D., David T. Smith, M. D., Roger D. Baker, M. D., Jasper L. Callaway, M. D., and Donald S. Martin, M. D. W. B. Saunders Company, Philadelphia, 1954. Price \$6.50.

This book is the second edition of a manual originally published in 1943 as one of the series of Military Medical Manuals prepared during World War II under the auspices of the National Research Council. It presents, in a clear, concise style, the mycology, the clinical findings, pathology, diagnosis and treatment of the fungus diseases of man. It also lists such pertinent information as geographic distribution, X-ray findings, and prognosis of this group of diseases. Because of its broad scope, this book can serve almost every individual in the medical profession. The thorough discussions, enhanced by many excellent clinical photographs, can guide clinicians in a consideration of differential diagnoses.

Many of the fungus diseases have been given more extensive discussion than in the first edition and separate chapters on nocardiosis and tinea nigra palmaris have been added.

This manual is an invaluable aid in the diagnostic bacteriology or mycology laboratory. Mycologic methods are presented thoroughly and supplemented

with photographs. However, it is not, nor is it intended to be, a beginner's outline in laboratory mycology. The Manual of Clinical Mycology is a worthwhile addition to any medical library.

Anne S. Adams

DEATHS

DR. A. De L. B. SALTERS, DIES

A. De Land Blackwood Salters, 76, physician, civic and religious leader of Florence, died May 28 of a heart attack.

Dr. Salters was born near Kingstree, Nov. 9, 1877. He had been a resident of Florence for 36 years. He was associated with McLeod Infirmary, under the late Dr. F. H. McLeod, as head of internal medicine and pediatrics. For the last several years, he has been an active member of the staff of the Bruce and Saunders Memorial Hospitals.

He attended Presbyterian College, was a graduate of the University of South Carolina and attended the Medical College of South Carolina. He was also a graduate of the School of Medicine at the University of Maryland. He was a member of the First Presbyterian Church and an elder in the church for 35 years. Dr. Salters was a member of the Pee Dee and South Carolina Medical Associations.

SOUTH CAROLINIANA

Abstracts by Arthur V. Williams, M. D.

An Evaluation of Pulmonary Insufficiency in Asthma, Pulmonary Fibrosis and Other Types of Chronic Lung Diseases. Kelly T. McKee, M. D., South. Med. Jour. 46:859-864, Sept. '53.

Information obtainable in history and physical examination is inadequate for estimation of the degree of pulmonary insufficiency in chronic lung disease. Ventilatory tests (unlike those evaluating alveolo-respiratory function which are technically difficult) yield data of help in evaluating patients. Tests used are vital capacity, inspiratory capacity, expiratory reserve volume, residual volume, total lung volume, minute breathing volume at rest, maximal breathing capacity, index of intra-pulmonary mixing, breathing reserve ratio, residual air-total capacity ratio.

These tests are an objective measure of lung volumes, are of value in following patients for comparative information. They are also useful in weighing the efficiency of drugs as therapeutic agents in improving lung function.

It is felt these tests may be most helpful in quantitative evaluation of the degree of pulmonary dysfunction.

An Evaluation of the Evans Blue Dye T-1824 Method for Studying The Circulating Blood Volume. Whiting, James A., M. D., Spartanburg, S. C. and Holtz, M. D., Toledo, Ohio. Surg., Gynec., & Obst. Vol. 97, P 709-

718, Dec. 1953.

The authors review the current methods of determining the circulating blood volume and conclude that the use of T-1824 (Evans Blue) is practical for clinical use. The following points are illustrated by case summaries.

(a) Control of hypervolemia due to excessive transfusions.

(b) Selective restoration of hemoglobin before replacement of other deficits.

(c) Depression of total hemoglobin by malignant processes.

(d) Replacement in post-operative hemorrhage.

(e) Pre-operative replenishment to standard without hemoconcentration, following excessive repeated bleeding.

Rabies and the Doctor. Ben F. Wyman, M. D. South. Gen. Prac., 115:219-221, Oct. 1953.

The history, epidemiology and clinical picture of rabies is reviewed and the importance of rabies as a public health problem is stressed.

Rabies vaccine should be used in patients receiving wounds or bites made by the teeth of a rabid animal. A rabid animal is defined as one (1) proved by laboratory methods; (2) Clinically rabid by veterinary diagnosis; (3) Cannot be located after biting; (4) Animal

bites without provocation disappearing before brain lesions have had time to develop.

The vaccine should not be used for indirect exposures.

Control measures are given. The use of and development of avianized virus vaccine is observed.

Some Practical Aspects of Tetanus. George H. Bunch, Jr., Columbia, Tri-State Medical Jour., Oct. 1953, V-1, No. 8, P 31.

The author reviews the etiology, pathogenesis, and clinical aspects of tetanus. He discusses prophylaxis with toxoid and T.A.T. and the treatment of tetanus in detail. He suggests for treatment an initial dose of 50,000 units of anti-toxin intravenously and 5,000 units every eight hours either intravenously or intramuscularly. He also suggests 10,000 units about the wound before its excision.

The author concludes that treatment of tetanus is not satisfactory with a continuing mortality of about 50%. He makes a plea that attention be focused on the prophylactic aspects of this highly preventable disease.

Resistance Strain Gauge Arches for Direct Measurement of Heart Contractile Force in Animals. Boniface, K. J., Brodie, O. J., and Walton, R. P. Proc. Soc. Exper. Bio. & Med. 84:263-266, Mar. 53.

A strain gauge arche is described in detail. Enclosure of the electrical component in a metal casing presents insulator breakdown in body fluids. The use of the instrument in measuring heart contractile force in fully conscious, chronically operated dogs is summarized.

Disparity Between Fluid Intake and Renal Concentrating Deficit In Dogs with Diabetes Insipidus. Abner H. Levkoff, Truman W. Demmler and Allen D. Keller. American Journal of Physiology, V-176, P-25, Jan. 54.

Diabetes insipidus was produced in dogs by the hypothalamic puncture procedure. Renal concentration was assessed by osmotic loading when the animals were hydropenic. Since these dogs, in the hydropenic state, produced urine of over 800 MOs L(1/3 normal value) there was no need of drinking more than three times the usual amount of water. Spontaneous intake was far in excess of this. The pathological thirst must be equally as important as the polyuria and not secondary to it.

A reduction of water intake to one-half the amount drunk spontaneously when water was freely available did not cause dehydration symptoms.

Drug Addiction. Dana C. Mitchell, Columbia, S. C. Sou. Gen. Pract., V-115, P-235-237, Nov. 1953.

A case is reported of a patient with heart disease and arthritis who had become ad-

dicted to narcotics. Successful withdrawal in this patient is described.

The author states that not more than 10% of cases of drug addiction have their origin in drugs given by doctors.

He suggests that in disease in which an early fatal outcome is expected physicians may begin heavy use of narcotics too early and that patients are probably not benefited by these except in the presence of real pain.

It is stressed that the physician always be aware of the danger of addiction in long term illnesses requiring pain-relieving remedies and in certain personality types who have a low pain threshold.

Puerperal Inversion of the Uterus. James E. Bell, Jr., G. Fraser Wilson, and Lester A. Wilson (From Dept. of Ob. and Gyn., Med. Coll. of S. C.) Amer. Jour. of Obst. and Gyn., V 66, P 767-780.

Because of the rarity of puerperal inversion of the uterus and because the available literature is conflicting in the therapeutic procedures recommended, the authors analyze the data in a number of cases and outline a clear course of treatment.

American and English literature from 1940 to mid-1952 was studied and two additional cases discussed.

The following plan of therapy is suggested:

(a) Anticipation of inversion and more judicious management of the third stage of labor can lower the incidence.

(b) Recognition of inversion can be ensured by making cervical inspection or immediate puerperal vaginal examination a routine procedure.

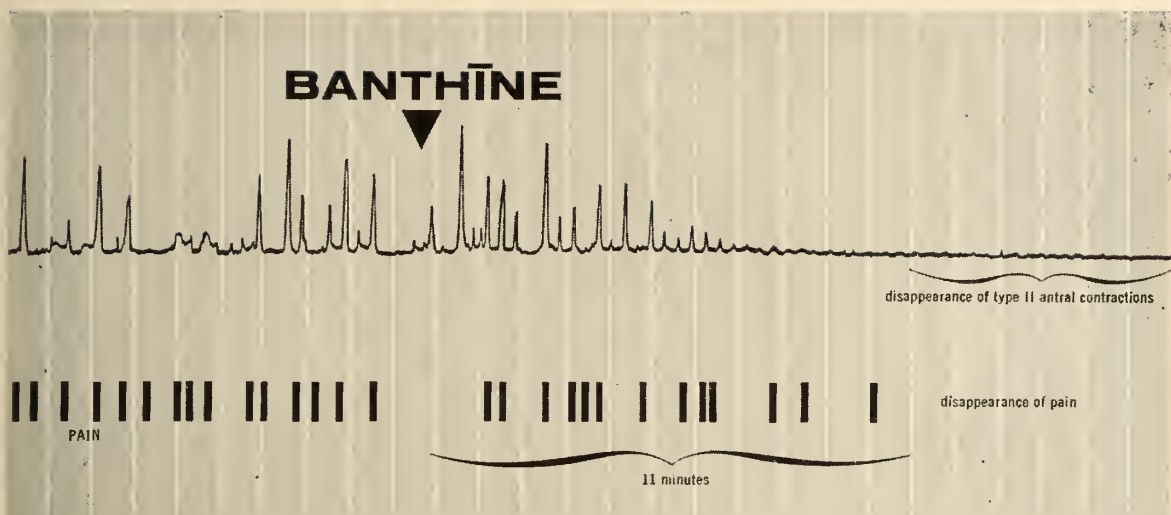
(c) With recognition within 30 minutes post-partum before cervical contraction, manual replacement should be immediately done, simultaneously starting therapy for shock.

(d) In the absence of hemorrhage and shock, in cases recognized before cervical contraction, manual replacement should be immediately done, regardless of time elapsed since occurrence.

(e) After 30 minutes, which time usually marks the beginning of cervical contraction, treatment should be directed toward conversion of blood loss and shock. After shock is corrected, gentle manual replacement should be made. If the cervix is tight, operative replacement should be done. (The Huntington procedure is satisfactory).

(f) Chronic inversion can be treated by manual reposition in some cases. Operative replacement by the Spinelli procedure is satisfactory when manual replacement fails.

Mental and Emotional Aspects of Allergy. Katherine Baylis MacInnes, M. D., Columbia, S. C. Southern Medical Journal V-46, P-1210-



Effect of 100 mg. of Banthine administered orally on antral gastric motility and duodenal ulcer pain.²

Hightower, N. C., Jr., and Gambill, E. E.: *Gastroenterology* 23:244 (Feb.) 1953

Banthine® Reduces Hypermotility and Hyperacidity in Peptic Ulcer

A recent evaluation of anticholinergic therapy in peptic ulcer emphasizes the fact that now the profession has at its disposal agents that are "effective in reducing both secretory and motor activity of the stomach."

The effect on motor activity is generally more pronounced and less variable than on secretion; pain relief is usually prompt; a high degree of effectiveness is noted in ambulatory ulcer patients.

Ruffin, J. M.; Texer, E. C., Jr.; Carter, D. D., and Baylin, G. J.: *J.A.M.A.* 153:1159 (Nov. 28) 1953.

With its proved anticholinergic effectiveness, Banthine has been found extremely useful in the medical management of active peptic ulcer, whether duodenal, gastric or marginal.

The immediate increase in subjective well-being and the simplicity of the Banthine regimen assures patient cooperation. The recommended initial therapeutic dose is 50 or 100 mg. (one or two tablets) every six hours around the clock, with subsequent individual adjustment. The usual measures of diet regulation, rest and relaxation should be followed.

Banthine is effective in other conditions caused by excess parasympathetic stimulation. These include hypertrophic gastritis, acute and chronic pancreatitis, biliary dyskinesia and hyperhidrosis. Banthine is contraindicated in the presence of glaucoma and should be used with caution in the presence of severe cardiac disease or prostatic hypertrophy.

Banthine® bromide (brand of methantheline bromide) is supplied in scored tablets of 50 mg. and in ampuls of 50 mg. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1214, Dec. 53.

The author states that there are three possible relationships between allergy and emotional change:

1—There may be no relationship.

2—Psychosomatic factors may make allergic manifestations worse.

3—Emotional or personality changes may be produced by allergic reaction in the nervous systems.

Illustrative case reports are presented. It is pointed out that mental and emotional aspects of allergic syndromes were described in early medical literature.

Frequently the psychosomatic aspect may be more incapacitating than the primary allergic reaction. Frequently, however, mental and emotional disturbances are relieved by removal of offending allergies.

Effect of Carbon Dioxide Excess on Contractile Force of Heart In Situ. Boniface, K. J.

and Brown, J. M. Amer. Jour. Physiol. 172:752-756, March 1953.

In 36 acute experiments a modified Cushing myocardiograph was used to measure the effect of carbon dioxide mixtures on the contractile force of a right ventricle segment. Heart contractile force decreased and the amplitude of systolic excursion decreased. Pronounced dilation occurred. These changes occurred in dogs given a high concentration of carbon dioxide. At times force was maintained with continual administration of gas and a "rebound" effect occurred when carbon dioxide was withdrawn.

Meniere's Disease. Annals of Allergy 11:190-193, Mar. Apr. 1953. George R. Laub, M. D., F.A.C.A., Columbia, S. C.

Two cases of Meniere's disease are reported having an allergic etiology. The literature is reviewed and the causes of Meniere's discussed.

Abstracts By Manly Stallworth, M. D.

Treatment of venous insufficiency of the lower extremities with note on the use of ascending phlebography, by Edgar D. Grady & E. M. Colvin. (Am. Surgeon 19:936-945, Oct. 1953)

The authors recommend detailed study of the entire extremity, including phlebography, in order to demonstrate the incompetent perforating veins, diseased deep veins and points of incompetency of the saphenous systems before decisions regarding treatment are made. Treatment of the superficial vein varies from injection of sclerosing drugs in varices to multiple division and stripping. Deep vein incompetency is sometimes treated by popliteal vein division.

Chronic intussusception carcinoid of the ileocecal valve and cecum: a case report. Whiting, J. A., Wallace, F. T. & Wilson, R. S. (Spartanburg) Am. Surgeon 19:1180-1183, Dec. 1953)

In a brief review of carcinoid of the gastrointestinal tract, the problem of diagnosis and metastasis is emphasized. An unusual carcinoid is reported in the case of a 57 yr. old woman who at operation showed chronic intussusception secondary to a carcinoid at the ileocecal junction. Recovery followed resection of the intussuscepted bowel.

Bile peritonitis — sequelae and treatment. Maguire, D. L. (Charleston) (Am. Surgeon 19:946-952, Oct. 1953)

In reviewing bile peritonitis, the author dis-

cusses the causes, the mortality of 60%, and the various methods of treatment.

The case reported was a 57 yr. old male who developed bile peritonitis 5 days after a routine type of cholecystectomy and common duct exploration by way of the cystic duct stump. Treatment consisted of supportive measures, open drainage of the subhepatic and subdiaphragmatic areas, followed in several months by abdominal exploration and resection of a stricture of the common duct. The entire convalescence was hindered by partial pyloric obstruction which, on subsequent operation proved to be due to adenocarcinoma of the stomach. The patient recovered.

Diverticula of the fourth portion of the duodenum. Whiting, James A., Wallace, Furman, T., and Wilson, Richard S. (Spartanburg) (Am. j. surg. 86:233-236, August 1953)

Following a review of the literature on diverticula of the duodenum, the authors report 2 cases of diverticula of the fourth portion of the duodenum treated successfully by excision.

Lower urinary tract infection in the female: an analysis of 153 cases. Chappell, B. S. (Columbia) (M. Times 81:683-690, October 1953)

The author reports 153 female patients who had lower urinary tract infection. The causes, clinical features and treatment are discussed. The study emphasized "the necessity for the recognition and correction of the contributing causes as more important than the antibiotic or chemotherapeutic agent used".

THE TEN POINT PROGRAM

M. L. MEADORS, EXECUTIVE SECRETARY AND COUNSEL

THE WOLVERTON AND SMITH BILLS FOR RE-INSURANCE

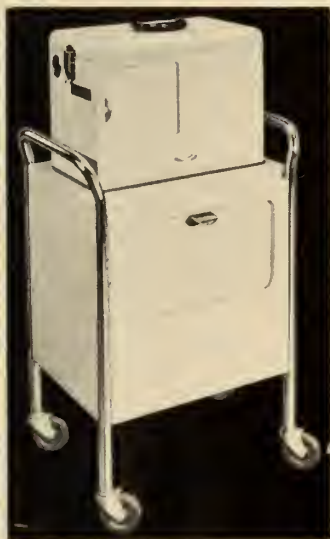
The following digest of the Senate Smith Bill (S.3114) and the House Wolverton Bill (H.R.8356), sets out the essential parts of this proposed legislation suggested and recommended in the President's Health message early this year. The measures were referred, respectively, to the Senate Committee on Labor and Public Welfare, and the House Committee on Interstate and Foreign Commerce, and are now under consideration by those bodies. The attitude of the A.M.A. is opposed to the legislation, although sympathetic generally with the aims expressed by its proponents. Mrs. Hobby, Secretary of the Department of Health, Education and Welfare, recently reiterated the Administration's support.

These identical bills embody the reinsurance proposal of the Administration and would, if enacted, be known as the Health Service Prepayment Plan Reinsurance Act. The bills, which have four titles, are intended according to their statement of purpose to "encourage and stimulate private initiative in making good and comprehensive health services generally accessible on reasonable terms, through adequate health service prepayment plans, to the maximum number of

people, (a) by providing technical advice and information, without charge, to health service prepayment plans and to the carriers and sponsors thereof, and (b) by making a form of reinsurance available for voluntary health service prepayment plans where such reinsurance is needed in order to stimulate the establishment and maintenance of adequate prepayment plans in areas, and with respect to services and classes of persons, for which they are needed."

Title I is devoted to a definition of the various terms used in the bill. The title would authorize the appointment of a National Advisory Council on Health Service Prepayment Plans of 12 members by the Secretary of the Department of Health, Education and Welfare, special advisory committees as determined by the Secretary to be necessary, and expert consultants. It also provides authority for the utilization of facilities and services of other governmental agencies and for the promulgation of necessary administrative regulations.

Title II would authorize the Secretary to conduct studies and collect and disseminate information concerning the organizational, actuarial, operational and other problems of health service prepayment plans and their carriers. Information and advice would be dis-



A Simple Office Procedure . . .

Taking a cardiogram with the Burdick Direct Recording Electrocardiograph is a rapid office procedure. No chemicals, no dark room, no waiting.

We will be glad to demonstrate in your office or in our showroom just how easy it is to run a cardiogram with the Burdick EK-2.

WE SERVICE WHAT WE SELL



W i n c h e s t e r

CAROLINAS HOUSE OF SERVICE



Winchester Surgical Supply Co.
119 East 7th St. Tel. 2-4109 Charlotte, N.C.

Winchester-Ritch Surgical Co.
421 W. Smith St. Tel. 5656 Greensboro, N.C.

tributed upon application, without charge.

Title III, which contains the more important substantive features of the bill, has 12 sections and covers 26 pages. In addition to setting out the basic authority for the provision of reinsurance by the Department of Health, Education and Welfare, the title outlines:

- (a) The form and content of the application for reinsurance describe the agreement which must be entered into and necessary accompanying documents;
- (b) The terms and conditions for approval of the application for reinsurance;
- (c) The basis for issuing to a carrier a reinsurance certificate;
- (d) The scope and extent of the reinsurance obligation of the government;
- (e) The method to be adopted in fixing premium charges for reinsurance;
- (f) The authority for establishing a Health Service Prepayment Plan Reinsurance Fund in the United States Treasury;
- (g) Authority for an initial appropriation of \$25,000,000 as advance capital as well as annual appropriations for five years to cover the administrative expenses involved in administering this title; and
- (h) Requirements relative to the payment of claims and authorizes the Secretary to terminate reinsurance involuntarily.

The most important provisions of Title III are contained in sections 303 and 305, which deal with the terms and conditions for approval of an application for reinsurance and the extent of the reinsurance obligation assumed by the government.

Section 303 would permit the Secretary of the Department to prescribe such terms and conditions governing the approval for reinsurance of health service prepayment plans as he believes will best promote the purposes of the bill, including but not limited to (1) kinds and types of health service prepayment plans which will be eligible, (2) minimum ranges of

health conditions to be covered, (3) minimum provisions as to the kind, quantity and duration of health services to be covered or provided under the plan, (4) deductible amounts and maximum liability amounts, (5) waiting periods, (6) provisions relative to policy holders bearing a proportion of the cost, (7) costs where services are provided by the carrier, (8) duration, cancelability and renewability of policies, and (9) other provisions which will promote the purposes of the bill.

This section would limit control of premium charges, provide for a 90 days' notice in case of changes in conditions and require that where medical and dental care or treatment is provided through salaried physicians or dentists that an applicant for reinsurance must have an organizational structure which vests control in connection with health services solely in duly licensed members of the professions involved.

Section 305 specifies in detail the scope and extent of the reinsurance obligation of the government. Under the contract envisioned the United States would be liable for 75% of the carrier's "reinsured costs." Such "reinsured costs" would be the amount by which benefit costs during a year exceed premium income less administrative costs. This section provides the formula by which the elements of "reinsured costs" are to be determined.

This section has detailed provisions which are applicable where the carrier itself furnishes the health services or does so through an affiliate. Rights, in the event of bankruptcy or insolvency, provisions limiting liability to the amount in the special Health Service Prepayment Plan Reinsurance Fund in the Treasury, among other items, are also discussed in this section.

Title IV deals with miscellaneous subjects such as the legal powers and responsibilities of the Secretary under the law, the necessity for audits, annual reports and the authority to hire persons in higher civil service grades are also spelled out. The Title, in addition, prohibits carriers under penalty of law from representing to the public that they are covered by reinsurance.

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

WHITTEN VILLAGE

**B. O. Whitten, M. D., Superintendent
Clinton, S. C.**

Institution with above title has good position to offer as Clinical Director to young, capable physician, preferably a South Carolinian but not necessarily. Person logically succeeds to Superintendency in few years, or refuses that office at his discretion. Anyone interested, communicate with the undersigned.

**B. O. Whitten, M. D.
Superintendent**

The Journal

of the

South Carolina Medical Association

VOLUME L

August, 1954

NUMBER 8

MINUTES OF THE HOUSE OF DELEGATES ONE HUNDRED AND SIXTH ANNUAL SESSION OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

MAY 11-12, 1954—OCEAN FOREST HOTEL, MYRTLE BEACH, S. C.

Tuesday, May 11—10:00 o'clock, A. M.

PRESIDING: Dr. C. R. F. Baker, President.

Call to order.

Invocation—Rev. G. H. Hodges, Pastor, Myrtle Beach Methodist Church.

Report of Credentials Committee, Dr. William C. Cantey.

Dr. Cantey: Mr. President, at the moment we have 52 certified delegates, in good standing. Twenty-five are necessary for a quorum.

Opening Remarks by the President:

Members of the House of Delegates, this year has been very quiet in the state medical association, quite different from the turbulent days of a dozen years ago when we had the draft and selective service to worry about and then followed by the Truman era when we were continuously perturbed about socialized medicine.

During the year we had only one called meeting of council. It was called to consider election of a member of the state board of medical examiners. Also we had one brush with the law. A bill to license homeopathic physicians in our state was introduced, but that was quickly dispatched by the efforts of Jack Meadors and Dave Adeock, chairman of the legislative committee.

This is the 106th meeting of the house of delegates. So far as I know there are no very controversial subjects to be brought before the house and no amendments to the constitution.

I hope the business session can be completed quickly and easily so that we can move on to a very interesting scientific meeting.

(Dr. Gaines is invited to come to the rostrum at this point)

Your president-elect needs no introduction to the delegates. You elected him and know him well. Perhaps I know him a little better than you, however, and I tell you that my association with him, during the past year, has been most stimulating. He has already made himself active in state and national medical proceedings. He is a hard worker and will be an honor to his office. It gives me pleasure to present Dr. Gaines.

DR. THOMAS R. GAINES (President-Elect): I thank you Dick, for those gracious remarks. I feel they are ill deserved but in order that your president-elect might in some small way fill the shoes of his illustrious predecessors I have gone about the state in some small manner this year, to widen my acquaintanceship and renew old acquaintances. It has been a very fine experience. I express my appreciation to the association for giving me this great honor and pledge to you my best efforts during the next year. Thank you.

THE CHAIR: At this point the reference committees are supposed to be announced and if you will refer to the blackboard on the right you will see that

these have been duly appointed. The names of the committees are followed by the members and the place of meeting is written opposite the membership. I do not believe there is any particular point in reading them, since they are clearly visible from every point of the room:

(For the record they are as follows)

1. Reports of Council & Officers:
W. Thomas Brockman, Chairman
F. E. Kredel
T. A. Timmons
A. W. Browning
G. M. Truluck
2. Legislation and Public Relations:
David F. Adeock, Chairman
W. W. Edwards
W. J. Snyder
Roderick Maedonald
A. C. Bozard
3. Public and Industrial Health:
R. L. Crawford
Edward M. Gunn
Ben N. Miller
Harry Tiller
J. A. Seigling
4. Amendments, Constitution and By-Laws:
T. G. Goldsmith
John F. Cuttino
J. B. Latimer
Lawrence Thackston
Wm. Weston, Jr.
5. Insurance, Blue Cross and Blue Shield:
Joe Cain, Chairman
J. D. Guess
Angus Hinson
A. F. Burnside
Clay W. Evatt
6. Miscellaneous Business:
W. L. Pressly, Chairman
L. B. Keels
D. C. Alford
R. L. Sanders
Bachman Smith
7. Credentials Committee:
Wm. C. Cantey, Chairman
R. W. Hancel
W. A. Wallace
Kirby Shealy
C. R. May

THE CHAIR: At this time the floor is open for the *Presentation of Resolutions and Recommendations* from the floor. Do we have any such resolutions or recommendations?

DR. HENRY W. MOORE, Columbia, S. C. (Recognized) I would like to ask if new motions would come under this particular part of the business?

THE CHAIR: That would come at this time, sir.

DR. HENRY W. MOORE: I would like to present a motion from the Columbia Medical Society and just ask what committee you would like to refer it to. (Reading Motion)

"1. That the South Carolina Medical Association herewith goes on record as recommending and favoring passage of a statute by the state legislature restricting the sale of lye to bulk packages for industrial and agricultural use.

"2. That no lye be sold in small containers for home use."

THE CHAIR: Do I hear a second to this motion?

(The motion was seconded)

There will be no discussion of these motions at the present time before the House of Delegates. Under the new set-up these motions are referred to the proper committee and I will refer that to the *Committee on Public and Industrial Health*.

THE CHAIR: At this point I wish to point out that this committee will meet this afternoon and any member of the Association, it does not have to be a delegate, any member of the Association is welcome to come to this committee and discuss any matter pertaining to this motion that they wish. In fact, I not only invite them, but I urge them to come to this committee meeting.

DR. ROBERT M. HOPE, Charleston, S. C. (Recognized) I have here a resolution which has been passed by the Charleston County Medical Society with request that it be presented to this body. (Reading resolution)

"Be it resolved that the South Carolina Medical Association cognizant of its responsibility to promote and further the public health and welfare of this state, and in order to provide its citizens with only the finest type of medical attention, and realizing the inequities and improper medical care being given by certain non-medical practitioners, does hereby pledge its complete support and facilities to see that this condition be remedied by any means whatsoever, including promoting passage of proper legislation if necessary, to protect the citizens of our state and property and adequately protect the public health and welfare.

Be it further resolved that the South Carolina Medical Association shall appoint its legal counsel to investigate any and all possibilities of attaining this goal.

Counsel shall report to the president at monthly intervals and quarterly reports on the progress of this project shall be disseminated to all county medical societies. A final and complete report shall be made no later than December 1, 1954."

Mr. President, I move that this resolution be adopted.

THE CHAIR: Do I hear a second to this motion? (The motion was seconded.) I will refer this to the *Committee on Public and Industrial Health*.

I would like to say that Council is already cognizant of this matter. I think Dr. Mayer will have something to say about it at a later date. We hope as many as are interested will come to the Committee and discuss it.

DR. WILLIAM WESTON, Jr. of Columbia, S. C. (Recognized)

This measure was brought up before the Columbia Medical Society, and it was discussed, and it was my belief the consensus of opinion was in favor of it. It has not been brought before the Columbia Medical Society. (Reading) "Continuation of Section 6:

In the event any elective officer resigns, dies, moves out of the State or is incapable of carrying out the duties of this office, then Chairman of Council shall appoint a qualified person to fill his office. This selection may be approved by 2/3 vote of members

of Council.

"Be it further amended that Council be called together by the Chairman of Council to act on any measure which three of its members (Council) in writing think is of serious import to the members of South Carolina Medical Association. If unable to decide, then the Chairman shall be empowered to have a special called meeting of the House of Delegates."

Mr. President, I move the adoption of this.

THE CHAIR: Do I hear a second to this motion? (It was duly seconded) This comes under Amendments to the By-Laws and will be referred to the *Committee on the Amendments of Constitution and By-Laws*.

THE CHAIR: Are there any further resolutions or recommendations to be brought before the House of Delegates at this time?

(There were no further resolutions or recommendations.)

REPORTS OF OFFICERS

THE CHAIR: I will now call upon our Executive Secretary to give his report at this time, Mr. Meadors.

REPORT OF THE EXECUTIVE SECRETARY AND COUNSEL

More than in any previous similar period, the major part of the time of the office staff in Florence during the past year has been occupied with the conduct of the Association's business affairs. Enrollment has increased considerably again and the payment of dues by members to both the State and American Medical Associations in the past few months has been more rapid and prompt than in any previous year in our experience.

As of May 8th, a total of 810 members have paid their dues for 1954 to the South Carolina Medical Association, and 811 have paid dues to the American Medical Association. This is a rather remarkable record. In view of the degree of unanimity with which the members of the State Medical Association elect to join the A.M.A., also, it is obvious that there is no need of compulsion in this regard so far as the doctors in South Carolina are concerned. Although it so appears from the above, actually not all members of the State organization join A.M.A. Both Associations provide exemption from dues for certain members, but on different grounds. Forty-four members in active military service, also, are carried on the rolls of both organizations without having to pay dues this year. In addition there are 146 Honorary Members of the State Association, and 133 members of A.M.A. who are dues exempt. Actually, therefore, the total number of active members of the State Association in good standing at this time is an even 1,000; and the total number of members of the South Carolina Medical Association who are likewise members in good standing of A.M.A. is 988. The necessary quota to retain South Carolina's two delegates to A.M.A. is, therefore, assured.

The total of membership for the year 1953, as of December 31st, was 1,298 members of the State organization and 1,184 for A.M.A. With the start already made in little more than four months of the new year, it is fairly certain that we will approach, if not exceed, this number for 1954. An interesting feature of the membership so far this year, is the number of new members who have been added to the rolls. So far in 1954, we have added the names of 57 new members to the list. The total number of new members for all of 1953 was 107. In 1953, we lost by death or otherwise, 54 members, resulting in a net gain of 53 for that year.

We collected in 1953, including dues to the A.M.A., and all other items, a total of \$61,709.80. Of this, A.M.A. dues amounted to \$26,240.00, and that amount plus a slight carry over from 1952 were remitted to the A.M.A. during last year.

As of January 1st, the business management of the Journal was added to the duties of the Executive office. Mrs. C. G. Watson has been retained for the handling of this phase of activities. The business of the Journal in 1953 accounted for \$12,525.25 of the income, from advertising. The cost of printing amounted to \$6,992.35, leaving a net gain from this source of \$5,532.90.

Current contracts in effect for advertising for 1954 represent a considerable increase in potential income from this source for the current year. As usual, of course, the majority of the advertising is handled through the Cooperative Bureau operated under the sponsorship of the American Medical Association. The mechanics of the handling of the Journal's business from the office in Florence has presented no complications since the editorship was transferred to Charleston under Dr. Waring. Mailing list changes, as in the past, are kept up through the Florence office, where all original records are kept and collections made and bills received and paid.

The property of the Association is amply covered by fire and other hazard insurance, and all employees connected with the business operations covered by a blanket Fidelity Bond in the amount of \$40,000.00.

Turning to some of the non-business activities of the office, these have followed the usual pattern of the past, but one or two new items were instituted since the last meeting.

In September, 1953, we began the issuance of a monthly Newsletter. Under the title, "Just a Moment, Doctor," this printed sheet is sent once a month to all members of the Association and others on the mailing list, carrying brief items of news of interest concerning the activities of the Association, its members, the A.M.A., and related organizations. Such reaction as has been noted has been favorable. We propose to continue the Newsletter so long as it seems to serve a useful purpose.

In October of last year, we obtained from the American Medical Association an attractive exhibit prepared by them, outlining the progress and advancement of medical care to its current high standard, and this was placed on exhibition at the State Fair in Columbia and the following week, at the Eastern Carolina Agricultural Fair in Florence. It is not possible to report the direct benefit from such an exhibit, but judging from the extent to which such media are used by many organizations, business and otherwise, there can scarcely be a doubt of the advantageous psychological effects. The cost involved was negligible, the A.M.A. furnishing the use of the exhibit free of charge, and the State Association paying only the transportation costs and other incidental costs connected with the preparation of the booth and its attendance. Members of the Woman's Auxiliary to the Columbia Medical Society took care of the exhibit most of the time in Columbia, and those of the Florence County Medical Society did likewise while the exhibit was at the fair in Florence.

The legislative scene in 1954 was more quiet than usual. The Session was a short one, this being an election year, with the Primary date moved up, and only one bit of legislation was introduced which had any particular interest, one way or the other, for the medical profession. This was a bill providing for the creation of a State Board of Homeopathic Medical Examiners. It was introduced in the Senate and referred to that body's Committee on Medical Affairs, from which it never emerged. We cooperated with the Legislative Committee, Dr. Dave F. Adcock, Chairman, and were able to place in the hands of the members of that Committee, certain material which had been in our files since last year concerning the background of the individuals interested in sponsoring this proposed legislation. It was obvious from the begin-

ning that the sponsors were not bona fide representatives of the approved Homeopathic school of medical practice, and within the past two weeks a letter has been received notifying us specifically of that fact.

Several weeks after this bill was introduced, notice appeared in the Columbia Record, as required by law, that within three days thereafter, application would be filed with the Secretary of State for the issuance of a charter to an eleemosynary corporation to be known as the South Carolina Homeopathic Council. The applicants were found to be non-residents of South Carolina, and one of them a "quack" with a long and interesting background. It was possible for steps to be taken to prevent the issuance of the charter on technical grounds for the time being, and enough information concerning the applicants is on hand to reasonably assure that the charter will not be issued if the effort is renewed.

Such was the calibre of the people undertaking to accomplish these steps, that even the Naturopathic Association in the State was opposed both to the bill and to the issuance of the eleemosynary charter.

The activities of the naturopaths, themselves, has continued to be a vexing problem. As a matter of fact, it appears to be increasing in scope and seriousness. The matter has been under more or less continuous investigation and several attempts have been made to obtain definite action with respect to certain individual naturopaths who obviously are among the more flagrant violators of common principles of morals and decency, if not the strict letter of the statutes involved. The language of the latter, however, is so broad and all-embracing that it has been impossible for definite action to be instituted. Resolutions have been considered by some of the county and district organizations and adopted by at least one, the Pee Dee Medical Association, calling attention to the revocation of the Naturopathic Licensing law in Tennessee with the resulting influx of these practitioners into South Carolina, and requesting the Attorney General of the State, for these reasons, to undertake a thorough investigation of their background and the so-called institutions where they are supposed to have been trained. It is impossible to say at this stage, what the outcome of such an investigation would be, in the event it is undertaken. Sooner or later, the legislative situation will be altered to an extent where, we believe, a repeal or drastic modification of the statute can be effected. This, after all, is the only real remedy, and it is the duty of the medical profession to the public of South Carolina, to continue its efforts toward that end.

The essay contest was conducted again this spring with good results. Through the cooperation of the Woman's Auxiliary, additional county societies were persuaded to award prizes locally and this increased interest. With the President of the sponsoring organization of the national contest a South Carolina doctor and member of the House of Delegates (Dr. Thomas G. Goldsmith) the essay contest had particular significance for us this year.

A study was made of the feasibility of the use of motion pictures prepared by the A.M.A. for telecasts as a public relations measure. Contacts with television stations in Columbia and Charleston were made, but due to various complications, nothing definite was worked out. Efforts along this line will be continued and a schedule of programs arranged within the next few months.

We have undertaken to give as much encouragement as possible to the development of medical public forums. Such projects are most feasible for activation by local county and metropolitan societies, but the office is ready to give any assistance requested by a county society in connection with such a project at any time.

We have undertaken to assist Dr. Robert Wilson as much as possible in connection with the physician placement program, and have, ourselves, had a number of contacts by letter and in person, from physicians seeking locations, and also from communities seeking physicians.

The biggest single task of the past year was the preparation of the 1954-55 Directory of members. As early as August, first steps were taken in commencing preparation of the Directory. A new feature added this time was the inclusion of the office telephone numbers of the members, and the Directory, containing the names of 1300 physicians, listed both alphabetically and geographically, with the biographical data and telephone numbers of all those by whom it was furnished, was mailed to the membership in January.

The following meetings, connected with the organization, or the work of the office with the profession in general, were attended during the year:

The American Medical Association's annual meeting in New York, and the interim session of the House of Delegates in St. Louis.

The Public Relations Institute of the A.M.A. in Chicago in September.

The Rural Health Conference in Dallas in March.

The Regional Legislative Conference organized by the Legislative Committee of the A.M.A., and held in Atlanta.

The A.M.A. Conference on Veterans' Affairs, likewise in Atlanta.

We were invited to participate on the regular program of the Medical Association of the State of Alabama at its annual meeting in Mobile, April 16. The paper presented on the subject, "The Doctor As An Individual," was well-received. The invitation to address the membership of the medical organization of a neighboring state was appreciated and we trust the effort may have served some useful purpose.

Preparation of the printed program was carried out by our office and all arrangements made with the Ocean Forest Hotel for the conduct of the present meeting. We likewise assisted the Alumni Association in a number of instances, in its preparation for the social activities of the occasion.

The sale of commercial exhibit spaces, likewise, was handled again by our office. A total of 36 spaces were sold for an aggregate sum of \$2,925, and the amount collected for the purpose of defraying the costs of the Convention.

The editing and management of the publication of the Woman's Auxiliary Bulletin was continued throughout the year, as was our contribution of the Ten Point Program Department to the Journal of the Association.

Correspondence concerning the matters discussed more or less in detail, in the foregoing pages, and generally, has been heavier in the past year than any since our connection with the work of the Association. It appears to be continuing to increase. The work is pleasant, enjoyable and agreeable. It is at times tedious, and frequently exacting as, for instance, in the course of the preparation of the Directory and the program for the annual meeting. Complicated situations arise sometimes with respect to the dues, which are, or are not payable by members in service, or who, for some other reason, may be entitled to exemption or refund. The records in this regard, are now perhaps more up-to-date and accurate than at any time since the collection of dues to A.M.A. was undertaken. We enjoy a very cordial relationship with the Department of Records and Circulation of the A.M.A. and through their cooperation and the cooperation of the members of the South Carolina Medical Association, have succeeded in working out a smooth arrangement of keeping the financial records of the two or-

ganizations.

The officers of the Association and members of Council have been most gracious and patient with our efforts. We appreciate the spirit of cordiality and cooperation which prevails in the relationship between our office and that of the officials of the organization and its membership.

Respectfully submitted,
M. L. Meadors

THE CHAIR: Thank you for your report, it will be referred to *Committee on Reports of Council and Officers*.

Report of the Secretary, Dr. Robert Wilson.

REPORT OF SECRETARY

During my past year my duties as Secretary of the South Carolina Medical Association have been varied and interesting. A great deal of correspondence and information comes to the Secretary and much of this has been referred to the attention of Council. Routine secretarial details have been handled as expeditiously as possible and during the past year I have attended an official AMA conference on Placement Service in Asheville, N. C. in September, the Sixth Annual Medical Public Relations Conference in conjunction with the Meeting of the American Medical Association in St. Louis in December 1953 and an AMA Conference on Political and Public Affairs in Atlanta, Ga. in January 1954. The information, suggestions and conclusions of these conferences have been most helpful in handling some of the matters of Association work.

Much of my time and efforts during the past year have been devoted to the establishment of the Professional Placement Service for the state. Your attention is called to a report on this which was published in the April issue of the Journal, detailing the purpose and operation of this service. Many inquiries from interested physicians have been received and I would further stress the fact that the success of this service depends altogether on the information furnished as to the availability and suitability of communities needing physicians. The responsibility for reporting such opportunities to the Placement Service cannot devolve on any one individual but must depend on each one who knows of any opportunity reporting this to the service so that this information can be relayed to all inquirers.

As a part of this work I have undertaken during the past year to make a survey of the physicians practicing in the state and the type of practice in which they are engaged; adequate replies from all but four counties have been received and the details of this survey have been published in a table in the April issue of the Journal. Your attention is also called to an exhibit of this survey near the Registration Desk.

I would also like to report that a chapter of the Student American Medical Association has been established within the past few weeks at the Medical College, perhaps partly due to the fact that a student observer was sent to the Chicago sessions of this organization in June 1953, sponsored by the South Carolina Medical Association.

I have no recommendations or suggestions to make to the House of Delegates at this time but I will say again that I have enjoyed my work as Secretary of the Association and I would like to thank the House of Delegates for the honor and privilege of having served you in this capacity.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

Report of the Treasurer, Dr. Howard Stokes.

TREASURERS REPORT

The year 1953 has been very satisfactory from an administrative standpoint for the treasurers office. The state membership has been increased somewhat but

collections were handled with greater dispatch. This is due in great part to the time, effort and patience exercised by the County Secretaries. While the secretaries in the larger counties have handled their members in their usual efficient manner, the satisfactory picture has only been complete because the secretaries of the smaller county societies have also contributed their time to the task of collecting the state and AMA dues.

As reported in the Audit of the Association, our finances are in good condition. Total revenue was \$61,709.80 with expenditures amounting to \$59,894.16. This leaves a difference of only \$1,815.64 for the year which is not quite \$2.00 surplus per member. This expenditure of funds has been due primarily to additional traveling expenses for the officers of the Association and seems to the treasurer, money well spent. I mention this since there has been an average of about \$4.00 surplus per member for the past several years.

A review of the audit for 1953 shows the following:

INCOME

1. Dues: State \$18,349.00 Number Members 1,079
AMA 26,240.00 Number Members 1,045

2. Other Incomes

(a) Journal Advertising \$12,525.25
(b) Medical Directories 41.25
(c) Emblems 55.25
(d) Collections Fee AMA 905.68
(e) Interest 175.00

Expenditures

(a) AMA 27,337.00
(b) Journal
(1) Printing 6,992.35
(2) Editor 1,500.00
(3) Equipment none
(4) Incidentals none
(5) Business Manager 900.00

(c) Executive Office

(1) Executive Director 7,200.00
(2) Secretary 2,840.00
(3) Secretary 1,820.00
(4) Travel Expense 1,164.75
(5) Incidentals (Office Exp.) 2,450.32

(d) Officers Expenses

(a) President 684.07
(b) Secretary 487.87
(c) Treasurer 99.00
(d) A. M. A. Delegate 753.76

4. Misc. Taxes, etc.

Legislative Survey 3,326.50

5. Fixed Assets (Furniture & Fixtures)

Balance on Hand 3,867.13

(1) Banks 23,362.80

(2) Bonds 10,000.00

(3) Building and Loan 10,000.00

Total Assets 43,362.80

The U. S. Gov't bonds are drawing interest at rate of 2.9% and the Building and Loan deposits at 3%. (Since the first of the year, the Bank account has been changed slightly. \$10,000.00 has been placed in the S. C. National Bank and is drawing interest at the rate of 2%).

The treasurer wishes to again thank the Executive Director, Mr. Meadors and his entire staff for their untiring and devoted assistance. The work of the treasurer has increased over the years and only through the cooperation of the Business office has the treasurer been able to function with even his present degree of efficiency without additional expense to the State Association. It must be remembered, however, that the great bulk of the Business of this office is still handled by the personnel of the Business office.

Report of the Editor of the Journal, Dr. Joe Waring, of Charleston, S. C.

DR. JOSEPH I. WARING (Recognized):—

Your editor has been in office for only four months, so he has very little to report. We have tried to make some changes in the Journal which we thought would be for the better and the editor would be most happy to have any comments or suggestions from any delegate or members of the Association. I would like to point out that no Journal can be a successful one simply by editing, it must have good sound material to make it a proper publication and it would be an aim of the editor and editorial board to make our State Journal the best in the country.

Report of Chairman of Council, Dr. O. B. Mayer.

REPORT OF CHAIRMAN OF COUNCIL

The Association's affairs for 1953 are believed to be in good condition. No major problems came up during the year.

The Council you elected for 1953 held its first meeting on May 7, 1953, and organized as follows:

Dr. C. N. Wyatt, Vice-Chairman

Dr. A. C. Bozard, Clerk

Dr. Robert Wilson, Secretary

Dr. Julian Price was re-elected Editor of the Journal

Dr. J. I. Waring, Assistant-Editor

Mr. M. L. Meadors, Executive Secretary

The budget submitted for the coming year was the same as for the previous year and was adopted.

Secretary

Office help \$ 900.00
Office expense, supplies, Tel. & Tel. 600.00
Travel 500.00

Total

\$2,000.00

Editor

Salary \$ 1,200.00
Office Assistant 900.00
Office expense 300.00

Total

\$ 2,400.00

(Plus cost of publication of the Journal)

Executive Secretary (including Treasurer)

Salary (Executive Secretary) \$ 7,200.00
Office help 6,000.00
Travel 1,500.00
Office rent 600.00
Office supplies 750.00
Tel. & Tel. 500.00
Heat, lights, water 150.00
Conferences and other Public Relations Act. 500.00
Bond Premium 155.00

Total

\$17,355.00

The Woman's Auxiliary—\$.50 per member (estimated) \$ 600.00

General Contingent Fund \$ 1,000.00

The Historical Commission was allocated \$500.00 if so much for the year was necessary and \$200.00 was approved for the Committee on Infant Mortality.

The Executive Secretary was directed to take over the business management of the Journal, relieving the Editor of this responsibility.

Dr. William Weston, Jr. moved that the Executive Secretary prepare the scientific program and the list of Delegates one month prior to the annual meeting if possible. The date for the meeting was tentatively set for May 11, 12, & 13.

Dr. C. R. F. Baker suggested that a cruise-meeting for the Association be considered and he was requested to appoint a committee to study the feasibility of such a plan.

The full minutes of this Council Meeting appeared in the June 1953 issue of the Journal.

Council met again on Sept. 23, 1953, which was the only call-meeting of the year, primarily to consider filling the vacancy on the State Board of Medical Examiners caused by the resignation of Dr. Carl West.

After discussion, the Executive Secretary advised Council that it was questionable if authority existed under the Association's new Constitution and By-Laws to fill vacancies on boards appointed by the Governor on nomination by the State Association. Accordingly, the vacancy was not filled, and the matter referred to the House of Delegates. Council requests the House of Delegates to advise whether authority exists to fill such vacancies and if so, what section of Constitution and By-Laws is applicable, and if not, Council requests guidance from the House of Delegates should similar vacancies arise in the future.

Reports were received from Dr. C. L. Guyton on the Civilian Defense meeting held during the annual AMA meeting in N. Y. in June 1953; also from Mr. C. H. Banov on the Student AMA convention in Chicago in June 1953. The high school Essay Contest was approved for the coming year. Dr. J. I. Waring recommended that a committee on School Health be established. This was referred to the House of Delegates.

The Chair was directed to appoint a committee to attend the meeting in Atlanta regarding the policy of the AMA on Veterans' non-service disability. The Chair later named the following committee: Dr. Lawrence Thackston, Orangeburg, Chairman, Dr. James T. Green, Columbia, Dr. Bachman Smith, Charleston.

A letter of resignation as a delegate to the AMA was read from Dr. Julian Price. It was accepted with regret and Dr. Price was extended thanks for his valuable service and congratulated on his election as AMA trustee. The Chair ruled that Dr. J. D. Guess was the alternate delegate, elected to succeed Dr. Price.

Mr. Meadors informed Council of the possibility that the Naturopaths might institute a suit against the state of S. C. to allow them the right to prescribe narcotics. A motion was passed authorizing Mr. Meadors to file a brief should such action occur.

A request from the Paul Revere Life Insurance Company for a letter of reliability was granted.

An expense account not to exceed \$50.00 a month was authorized for clerical help for the Assistant Editor of the Journal beginning January 1954.

The full minutes of this meeting appeared in the November 1953 Journal.

The Journal has appeared in the usual monthly issues, in a creditable manner, and continues to enjoy a substantial advertising patronage.

On January 1, 1954, Dr. Julian Price, who for years has been the outstanding Editor of the Journal, resigned and Dr. J. I. Waring assumed full editorship. Dr. Waring has had unusual publishing experience, and with his skill in writing, it is expected the Journal will maintain its high standard, and no doubt, will continue to grow.

The finances of the Association are in good order. An audit of the Association's books by the accounting firm, Jaillette and Brunson, revealed that cash on hand on December 31, 1953, was \$23,362.80, of this amount \$10,000.00 is representative of payment of the loan of \$10,000.00 from the S. C. Medical Care Plan. On January 1, 1954, the Association had cash on hand \$11,867.67. The operating profit for the year 1953 was \$1,815.64, which is not a very large margin.

Council met yesterday, and in addition to routine business, the following matters were acted upon:

Dr. Whitten, Director of the school for the mentally deficient at Clinton, and Dr. Hall, the Superintendent of the South Carolina State Hospital, both requested an expression from Council on the same subject. Because of the inability to secure licensed doctors, it

has been necessary that they employ displaced persons who are physicians but not licensed in South Carolina for the care of the patients of these institutions. The Secretary was directed to write Dr. Whitten and Dr. Hall advising that Council recognizes the necessity of their making this arrangement under the circumstances, but that we are unable to officially approve it.

Dr. J. D. Guess submitted his resignation as an alternate delegate to the American Medical Association in the place of Dr. Julian P. Price. The suggestion was then made that the terms of the two delegates from South Carolina which now run concurrently, be altered so that their dates of termination will be staggered. Council therefore recommends:

a. That the resignation of Dr. Guess be accepted with regret.

b. That the term of office formerly held by Dr. Price, in which Dr. Guess has served as alternate, be terminated as of December 31, 1954, and that a delegate be elected at this meeting to succeed Dr. Price for a term of two years, beginning January 1, 1955.

c. That a substitute alternate delegate for Dr. Guess be elected to complete the term left vacant by his resignation for the balance of 1954.

Council then took action with respect to two bills pending in Congress, affecting in some measure the members of the medical profession. It recommends that the House go on record as disapproving the bill to extend the provisions of the compulsory Social Security Act to include the members of the medical profession and, second, that the House approve the Keogh-Reed bills now pending to provide for voluntary pension plans.

Following the reported trend of a number of state medical societies and the recommendation of the A.M.A., Council suggests to the House that the name of the State Grievance Committee be changed to the Mediation Committee of the South Carolina Medical Association.

Dr. J. Dechard Guess, president of the South Carolina Medical Care Plan made a full report concerning that organization and this will be presented to the House of Delegates at the time of the regular meeting of the corporation.

The elevation of Dr. Julian P. Price to the Board of Trustees of the American Medical Association was noted. In recognition of the honor thus brought to our Association, a motion was made and adopted by Council to suggest to the House of Delegates a change in the By-Laws of the Association to provide that any Trustee or other official of the A.M.A. automatically become an ex officio member of the Council of the South Carolina Medical Association.

In conclusion, the Chairman would like to take this opportunity to express to the members of Council his appreciation for their unfailing cooperation and thoughtful attention to all matters, and again to invite the members of the Association to call upon Council at any time that we may be of help.

Respectfully submitted,

O. B. Mayer, M. D., Chairman

THE CHAIR: The reports of the Secretary, Treasurer, Editor of the Journal, and Report of Council will be referred to *Committee on Reports of Council and Officers*.

In Dr. Mayer's report I believe there are two items which refer to changes in the by-laws. I would like to ask Dr. Mayer to refer those parts of his report, if possible to the *Committee on Amendments to the Constitution and By-Laws*. The rest of that report will be referred to the Committee on Reports of Council and Officers.

Reports will now be heard from the Delegates to AMA, Dr. William Weston, Jr.

REPORT OF DELEGATE TO AMERICAN
MEDICAL ASSOCIATION
TO THE
SOUTH CAROLINA MEDICAL ASSOCIATION
New York City—June 1-5, 1953

See J.A.M.A. Vol. 152 #8, Pgs. 719-743.

Vol. 152 #9, Pgs. 827-856

Address of the President, Dr. Louis H. Bauer.

Approves of the present set up as outlined by President Eisenhower.

"Doctors must be stimulated to accept their responsibility of making medical care available at all hours of day or night.

Advices the increase in general practitioners and less specialization.

Address of the President-elect, Dr. Edward J. McCormick.

Nine-point program.

"Too many physicians have been isolationists within their communities. Local societies should encourage each individual member to participate in some civic undertaking. We physicians should be rendering health leadership in all service clubs, fraternal organizations, Parent-Teacher Association groups, church associations, and unions. We cannot expect these organizations to be interested in our problems if we are not interested in theirs. We must rub elbows on a social and organizational basis with persons outside the profession.

Much discussion transpired regarding the care of veterans, and I am quoting the recommendations (J.A.M.A. Vol. 152 No. 8, Pg. 733):

"Part One—Your Committee recommends with respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to the following two categories:

- (a) Veterans with peace time or wartime service whose disabilities or diseases are 'service-incurred or aggravated;
- and
- (b) Within the limits of existing facilities to veterans with wartime service suffering from tuberculosis or psychiatric or neurological disorders of non-service-connected origin, who are unable to defray the expenses of necessary hospitalization.

"Your Committee recommends that the provision of medical care and hospitalization in Veterans Administration hospitals for the remaining groups of veterans with non-service-connected disabilities be discontinued and that the responsibility for the care of such veterans revert to the individual and the community, where it rightfully belongs."

Regarding the resolution you had me to present (Resolution on Social Security System, J.A.M.A. Vol. 152 No. 9)

Resolution on Social Security System

"Dr. William Weston, South Carolina, introduced the following resolution:

Resolved, That the South Carolina Medical Association, in regular session assembled on May 6, 1953, instruct its delegates to present a resolution to the House of Delegates of the American Medical Association urging that body to endorse and to cooperate in, if possible, a full study of the present Social Security System and endeavor to work out a plan whereby it can be established and operated on a sound financial and actuarial basis."

It was referred by the Board of Trustees to the Council on Medical Service for consideration and reply.

"This problem is being studied conjointly with the commission appointed by President Eisenhower and a subcommittee of the Ways and Means Committee of

the House of Representatives, under the chairmanship of Carl Curtis of Nebraska, which is studying the problem of social security.

Your reference committee accepts this as a progress report by the Board of Trustees and the Council on Medical Service, and recommends a continuation of the study with a full report when a conclusion is reached.

Report of American Medical Education Foundation by Dr. Elmer L. Henderson:

"The Foundation has transferred in excess of \$1,650,000 to the National Fund for Medical Education and, in turn, that organization has made grants to the nation's 79 approved medical schools of more than \$2,918,000. The medical profession provided approximately 50% of the total dollars disbursed in the grants to our medical schools. The Foundation will make another transfer of funds to the National Fund on June 30, which we have every reason to believe will exceed one million dollars. This will bring the total raised and transferred to over \$2,650,000 during the 30 months that the Foundation has been in operation. In 1953, as in the previous year, we have set a goal for our efforts of \$2 million dollars, and we are extremely hopeful that as the year progresses we shall see that goal attained. The goal is a realistic one that will enable the medical profession to carry its share of the National Fund's goal of 10 million dollars, which will give the needed stimulus to business and industry to bring in the remaining 8 million dollars."

Individual doctors and medical auxiliaries are contributing considerable amounts.

Report of Reference Committee on Amendments to Constitution and By-Laws

"A member temporarily in the Armed Forces may be excused from the payment of American Medical Association dues, regardless of local dues exemption for the period beginning January 1 or July 1 following the date of the member's entrance into the service."

An able address by Commander of American Legion, Mr. Louis K. Gough, was heard, emphasizing the individual freedom and opposing socialized medicine. Both organizations have a common goal.

Dr. Frank H. Labey addressed the House of Delegates on National Fund for Medical Education. Election of Officers

Dr. Walter B. Martin of Norfolk, Virginia, President-elect.

Dr. Julian P. Price of Florence, South Carolina, was elected to serve the unexpired term of Dr. Walter B. Martin to the Board of Trustees.

St. Louis—December 1-4, 1953

J.A.M.A. Vol. 153, No. 17, Pgs. 1526-1555, Vol. 154, No. 1, Pgs. 63-67.

General Practitioner of the Year, Dr. Joseph I. Greenwell of New Haven, Kv., 80-year-old active practitioner, was presented the General Practitioner Gold Medal Award.

Remarks of the Speaker, Dr. James R. Reuling.

It is usually the lack of the individual responsibility that is the trouble, rather than what the County, State, or American Medical Association is doing or not doing. The fight against socialized medicine is not dead nor either dormant and we must be on our guard and do our duty.

Address of the President, Dr. Edward J. McCormick.

Reviewed the past six months in regard to his recommendations made in June, 1953, to find that there has been some improvement. The astonishing growth of voluntary health and hospital insurance is quite gratifying.

Presentation and Address of Dr. Chester S. Keefer, Special Assistant to the Secretary of the U. S. Department of Health, Education, and Welfare.

- (1) Improvement of Medical Education, especially in the high standard of the Medical Schools.

- (2) Hospital facilities depend on the requirements of the local communities and their response.
 - (3) The Health team—Public Health and its various branches.
 - (4) The medical profession and its allied professions, dentist, druggist, nurses, sanitary engineer, etc.
- The doctor must take the lead and show the way based on educational and scientific background.

He concludes his talk with a quote of two paragraphs from Dr. William H. Welch's address in 1910 as President of the A.M.A.

I recommend this talk to you and advise that you read and digest same. Keefer is a smart man and attempts to explain what he is doing in this position. Also he emphasizes the responsibility we as doctors and organized medicine must continue to hold in the care of patients.

Introduction and Address of President of American Dental Association, Dr. Leslie M. Fitzgerald.

"The united efforts of the American Medical Association and the American Dental Association also have done much to defeat unsound and ruinous legislation at both the national and local level."

Introduction and Address of President of Woman's Auxiliary, Mrs. Leo J. Schaefer.

"As Auxiliary members we have a twofold service to render, (1) education of ourselves in subjects relative to the medical profession and (2) bringing this message of medicine to our home communities through the organizations in which we hold membership. There was a time not too many years ago when it was not necessary for a physician's wife to be informed concerning health problems that affect the public, but today she must be informed or offer no comments."

Resolution on Chiropractic Treatment of Crippled Children.

"Dr. William Weston, Jr., South Carolina, introduced the following resolution, which was referred to the Reference Committee on Hygiene and Public Health:

Whereas, It has come to the attention of the South Carolina Medical Association that chiropractors are attempting to operate clinics and to engage in the treatment of crippled children under the auspices of crippled children's societies of certain states; therefore be it

Resolved, That the American Medical Association investigate this condition and advise the various states as required, and that they condemn the chiropractic treatment of cerebral palsy cases under the crippled children's societies' programs if and wherever this exists."

This should have read as being introduced by the Columbia Medical Society of South Carolina, as time did not permit the subject to be presented to the South Carolina Medical Association. The subject broke a week immediately preceeding the A.M.A. meeting.

Report of Reference Committee on Hygiene and Public Health.

"Res. No. 30 on Chiropractic Treatment of Crippled Children:

Your committee accepts this resolution with the following changes: That the American Medical Association condemn chiropractic or other cult treatment of cerebral palsy cases under the programs of crippled children's societies wherever they exist. It is the opinion of your committee that any investigation of this situation should be carried out at the local level."

Respectfully submitted,

William Weston, Jr., M. D.

Delegate from South Carolina to the American Medical Association

THE CHAIR: Thank you for this very complete report.

Dr. Guess was unable to attend the meeting in December.

Dr. Robert Wilson attended the meeting in St. Louis and I will call on Dr. Wilson at this time.

DR. ROBERT WILSON (Recognized): Dr. Weston has given you a full and complete report. I enjoyed attending the meeting very much. My chief duty was to assist Mrs. Baker in keeping Dr. Baker out of trouble engineered by the other delegate, Dr. Weston.

THE CHAIR: I appreciate your solicitude, it was a great help to me.

That ends the reports of Officers, all of which will be referred to the *Committee on Reports of Council and Officers*.

Is there any unfinished business? (There was none.)

DR. WARING: Will you specify as to which reference committee the reports of committees will go?

THE CHAIR: All reports of officers go to the Committee on Reports of Council and Officers, except I did ask Dr. Mayer to refer two parts of his report to the Committee on Amendments of Constitution and By-Laws, because his report called for an amendment to the By-Laws.

DR. WARING: Does that include all standing committees, such as the Committee on Insurance?

THE CHAIR: I will bring that up right at this point, Dr. Waring.

There are several standing committees throughout the year which have to be referred to reference committees. I will refer the Committee on Public Relations and the Committee on Legislation to Committee No. 2 (On the blackboard) which is the *Committee on Legislation and Public Relations*.

To Committee No. 3 (on the blackboard), which is *Committee on Public and Industrial Health*, I would like to refer the Committee on Maternal Welfare; the Committee on Indigent Care; the Committee on Rural Health; the Committee on Infant Mortality; the Committee on Gamma Globulin; the Committee on Industrial Health. It looks as if Committee No. 3 will have lots of business to attend to.

The Standing Committee on Insurance will be referred to the *Committee No. 5, Insurance, Blue Cross and Blue Shield*.

To the *Committee on Miscellaneous Business* I wish to refer the Standing Committee on Historical Medicine and the Standing Committee on Cancer Control, since there were so many referred above to the Committee on Public & Industrial Health.

THE CHAIR: I believe that completes all of the standing committee references. Would anybody like to have any of those committees repeated, so that I can tell where they are to be referred? (There was no answer).

NEW BUSINESS

THE CHAIR: The next on the agenda is "New Business" do I hear of any new business that is to be brought before the House of Delegates?

DR. WYMAN KING of Batesburg, S. C. I don't believe you gave us an opportunity to make a *supplemental report* on the Committee on Public Relations. I have a short supplemental report.

THE CHAIR: You will have an opportunity to present that to the proper *Reference Committee, on Legislation and Public Relations*. Would you prefer to read it at this time, if so, please do.

DR. WYMAN KING: Inasmuch as the business of The Committee on "Public Relations" is a continuing one, and not just a yearly affair, when three new members or more come to the committee by appointment or otherwise, before they are able to get their feet on the ground they have completed their work. We therefore recommend that the Committee be made

a more or less permanent one, by electing men for three (3) year terms or appointing them and staggering the term so that old men would stay on for a short while, while the new ones learn the ropes.

THE CHAIR: This is referred to the *Committee on Legislation and Public Relations*.

(Ten minutes recess granted—doctors are urged to see exhibits and talk with exhibitors.)

THE CHAIR: I will call the meeting of the House of Delegates to order again. I am sorry that so many have departed. They seem to have found things of interest at other points in the building.

At this time I am going to return to *NEW BUSINESS* for just a minute. Dr. Goldsmith is recognized. he has something that will only take a minute that he wishes to read to the House of Delegates. It seems important to me so I am going to revert to New Business on the program and call on him.

DR. GOLDSMITH: Thank you, Dr. Baker. This is not perhaps entirely new business. It is really information. As Council reported, the A.M.A. is in favor of treating veterans with service-connected disability only and also it includes veterans with tuberculosis or other disabling disease or veterans needing psychiatric help, provided the veteran is not able to pay for it.

As President of the Association of American Physicians and Surgeons, in Jackson, Mississippi, On April 1-3, we passed resolutions against veterans being treated for anything except service-connected disability. A former president of the A.M.A., Dr. Shoulders of Memphis, Tenn., is going to present before the House of Delegates of A.M.A., a plan he calls the "Tennessee Plan" which will include the treating of all veterans, regardless of service-connected disability, in veterans hospitals. This is, of course, in direct contrast of what the A.M.A. has gone on record as favoring. But, it is coming up again in the House of Delegates of the A.M.A. It will be known as the "Tennessee Plan" and Dr. Shoulders is contacting A.M.A. delegates over the country trying to get their approval and support. If a plan like that should pass, we would have socialized medicine. There are 80,000 veterans each month being separated from the service, who would be entitled to socialized medical care in V.A. Hospitals. If you bring their dependents and families in, we will have socialized medicine before we know it.

I bring this information to you in hopes that the delegates of A.M.A. will go out, knowing what the "Shoulders Plan" so-called "Tennessee Plan" is and that they will go out and fight it. If they go out and favor it we will have socialized medicine. Thank you.

THE CHAIR: Thank you Dr. Goldsmith. I will refer these remarks to the *Committee on Miscellaneous Business*.

Dr. Goldsmith, I believe both of our delegates to the A.M.A. are missing at the present time. It might be well for you to talk to them, personally, sometime during the meeting. I don't see Dr. Weston or Dr. Wilson, and I wish you would see them.

SPECIAL ORDER—The Annual Meeting of the Corporation, The South Carolina Medical Care Plan.

DR. GUESS—Presiding:

(The House of Delegates of South Carolina Medical Association arose and immediately resat as Members of the Corporation of The South Carolina Medical Care Plan.)

(After transaction of business)

(The Members of the Corporation of the South Carolina Medical Care Plan arose and immediately resat as The House of Delegates of the South Carolina Medical Association.)

1:30 P. M. Adjournment until 9:30 A. M. Wednesday, May 12, 1951.

MINUTES OF THE HOUSE OF DELEGATES MAY 12, 1951

WEDNESDAY—9:30 A. M.

PRESIDING—Dr. C. R. F. Baker, President

THE CHAIR: I will ask the meeting of the House of Delegates to please come to order.

(Announcement made requesting all voting members to sit up to the front and the others sit behind, with a separation of several of the seats, for the reason that it might possibly make it a little easier to count the votes in case of a close decision.)

We have a couple of telegrams—one is greetings from the Southern Medical Association, it is from Birmingham, Ala., from C. P. Loran, Secretary Manager, Southern Medical Association, "Greetings. Hope you are having a very splendid State Meeting. Regards and Good Wishes."

We appreciate that message very much.

I am sure that all of the members of this house of delegates will be very grieved to learn that Dr. Julian Price lost his father night before last. I think that Julian is one of the most outstanding members of our association and I am sure that all of us sympathize with him in his loss. I will read the wire from Julian: "My father died last night. Sorry unable to attend meeting this year, the first meeting I have missed in 20 years. Best wishes to you and all my other friends. Julian Price."

THE CHAIR: I would also like to say that Council sent Julian a wire of sympathy and council also took up a collection to send some flowers to the funeral, but I understand the family requested that there be no flowers, consequently we will have to do something else instead of sending those flowers.

REPORTS OF REFERENCE COMMITTEES

THE CHAIR: The first order of business this morning is a report of the Reference Committees. At this time I will call upon the Chairman of the first committee, Dr. Thomas Brockman, to give us the benefit of his report, Dr. Brockman.

DR. THOMAS BROCKMAN: The Reference Committee on Reports of Council and Officers wishes to approve most of the reports we have read. We would like to emphasize Dr. William Weston, Jr.'s report in regard to indigent veterans and make it very clear that indigent veterans on the local level should be treated the same as service connected cases. (We are afraid to say indigent veterans, on a national level, that doesn't seem to mean the same thing.) That point was emphasized because it was brought out that the American Legion had thought that the A.M.A. was a little bit unsympathetic about that.

We would like to approve council's report with regard to the A.M.A. delegate's term of office being staggered.

This Committee feels very strongly that the Naturopath must get out of South Carolina and that as a group we are all responsible in a way for his being here. Individually, each of us has the feeling that we can't afford to be embarrassed by discussing the naturopaths locally. But as a group we feel that this society should urge the Attorney General to do as our Mr. Meadors suggested, investigate them.

In regard to Blue Cross and Blue Shield and all other hospital insurance, we would like to urge every physician to take time to explain to his patients the predicament that we are coming to, that is,—hospital insurance will have to keep raising rates until it becomes prohibitive for all of us, and then what would follow, we can't say. We think it has been a hard thing for a doctor to place himself in an insurance man's position and try to discharge his patient earlier than the patient wants to be discharged, but the time has come when everyone of us must do it or else face a failure in Blue Cross and Blue Shield, and probably some of the other good companies. All of them are

losing money on hospital insurance, I thank you.

(The following is Dr. Brockman's closing remark, which is a repetition of some of the above, but is very concisely stated and to the point. "The time has come when we doctors must explain, take time to explain to the patient that hospital insurance will become prohibitive unless we protect it and use it when we are sick and not just for examinations, rest, etc.")

THE CHAIR: Thank you, Dr. Brockman. Do you feel there is anything in the report that needs to be presented to the House of Delegates for action? You want it approved as read?

DR. BROCKMAN: We didn't find anything to bring back to the House.

THE CHAIR: I want to thank Dr. Brockman. There is one item, regarding the election of the delegate of the A.M.A., which will be brought up in a later report from one of the Reference Committees. I do not believe there is any controversial matter included in this report.

DR. WESTON, JR.: (Recognized) Mr. President, I may be wrong, but I think it is controversial that Dr. Brockman's report stated that they thought a veteran who was an indigent should be taken care of by the American Legion or some organization of that kind. I think from what I have learned in the A.M.A., as your delegate that this is not their belief, that they think the indigent person belongs to the local community and that he should be taken care of there.

This is just an inroad and method to get in and break up our way of life, to prove socialized medicine is justified. That is something we do not believe. If a veteran is indigent—it is our responsibility in our communities. They have only approved a few conditions, the psychopath and the protracted TB, as being eligible and that is not service connected. Those are the only two things that I can recall the A.M.A. approved of, or the American Legion or the Veterans Administration taking care of. I would like to make it clear, I think it is our problem in the own local community to care for the indigent. It is just an inroad and method of getting in and breaking up the American Way of doing things.

THE CHAIR: Do you wish to make any motion in regards to this matter, Dr. Weston?

DR. WESTON: No, I only wish to make those remarks.

THE CHAIR: Do I hear a motion that Dr. Brockman's report be received as information? (It is so moved, seconded by Dr. Adcock; there was no discussion, the vote was taken and passed unanimously.) The Chair: It is approved and so ordered.

THE CHAIR: Dr. Goldsmith, I believe you wanted to mention something at this point. Dr. Goldsmith is president of the Association of American Physicians and Surgeons. We are honored to have such an officer in this state, Dr. Goldsmith.

DR. GOLDSMITH: In the report of Council, yesterday, they stated they were going to sponsor again for 1955 the Essay Contest which is sponsored nationally by the American Physicians and Surgeons. I thought it just fitting that I give you a little background why this essay was instituted by this organization. In so doing I will have to give you a little background of the organization.

The Association of American Physicians & Surgeons was organized in 1943 by a group of doctors in Indiana, who were members of their state and county societies and members of the AMA. Membership in the organization is voluntary. A member must be eligible to membership in the AMA before he can be a member of the Association of American Physicians and Surgeons. We represent medicine in a business, socio-economic field, with a legislative education and freedom program. In 1930 in Teachers College in Columbia University, Professor Dewey and Professor

Counts instituted what we have now learned to call 'progressive education.' The idea has been disseminated into all the schools, practically, in the United States, since that date and in fifteen years time it has become so engrossed in the schools that it was showing up in the students' attitude of things.

In 1930 Professor Counts, in one of his reports stated that the present social order of the United States, which was based on free market economy, free enterprise, and the American way of life, that that order must be replaced by a socialistic ideology, and so, that was the beginning of the idea of progressive education.

In a few years' time it has spread to a number of the schools in the United States—in 1945, Purdue University conducted an opinion poll of high school students; one of the questions was their opinion on Socialized Medicine. 80 percent of the students, who replied to that questionnaire favored socialized medicine. That is astounding.

At this time the American Physicians and Surgeons saw the need of instituting some means whereby the students could be indoctrinated again and their minds saved again and that they might understand the free market economy that this country is built on. They instituted the Essay Contest in 1947. The first year and for the next seven years the subject was and remained "Why the Private Practice of Medicine furnishes this Country with the Finest Medical Care."

That was in 1947. In 1950 the second Purdue Opinion Poll was instituted in the High Schools and the same question on Socialized medicine was asked. 55 percent of those returning the questionnaire favored socialized medicine. So, you see in three years time we feel the Essay Contest has accomplished something, from 80% to 55% in three years, but the 55% is still too much.

The first year in 1947 the Essay Contest furnished approximately 700 of the package libraries, which are sent free to the schools, so that the students can use them as reference libraries. In 1953 there were over 1600 package libraries sent out. In 1954 at our annual meeting in Jackson, Miss., in April of this year we decided to change the title slightly and to shorten it. That was one of the objections the schools had, the title was entirely too long. In 1955 the Title will read "The Advantages of Private Practice of Medicine."

It delights me very much that this association has gone on record as sponsoring this contest for 1955. The contest this year was fairly well recognized over the state, but not like it should be. We had only 25 essays scattered over the state. I am proud to say that the boy from Greenville, who won second place in the Greenville Contest was winner of first place in South Carolina Essay Contest. He will be here tomorrow to read his essay and receive his reward.

THE CHAIR: Thank you, Dr. Goldsmith. Dr. Goldsmith was presented at this point because his essay was reported in Council's report and Dr. Brockman did not bring it out in his report. Council approved this contest for next year and gives prizes. Also Council suggested that these contests be sponsored on a local county basis in an effort to get more interest in the contest.

THE CHAIR: Next we will have the report of the *Committee on Legislation and Public Relations*, Dr. Dave F. Adcock, Chairman.

The report of this Committee was read by Dr. Adcock.

(DR. WESTON moved the adoption of this report and it is duly seconded, there was no discussion.)

THE CHAIR: You want to accept this in toto?

(It was agreed to accept the report in toto and it was voted on and passed.)

THE CHAIR: Next the report of the *Committee on*

Public and Industrial Health, Dr. R. L. Crawford, Chairman.

The Report of this Committee was read by Dr. Crawford.

THE CHAIR: Thank you Dr. Crawford, I don't believe there is anything particularly controversial in this report to be discussed, do I hear a motion that it be adopted.

(Motion was made that the report be adopted, this was seconded by Dr. Wyman. There was no discussion, the vote was taken and passed with no opposition vote. It was so ordered.)

THE CHAIR: I am going to do something a little unorthodox; we slipped something through on that last report of Dr. Adeock that should be considered and discussed a little more than we considered it then. He recommended that we have a press representative to try to take care of our newspaper publicity, in the state. Dr. Adeock's recommendation was brought to the attention of Council this morning and Council passed a recommendation approving the proposal of Dr. Adeock's committee.

That proposal, in substance, authorized the Association to employ a press representative at a reasonable fee to see that the association got favorable publicity throughout the state and they authorized the expenditure of a reasonable amount of money for this purpose, and as a reasonable amount they considered a maximum expenditure of Twelve Hundred (\$1200) Dollars per year.

(At the request of the Chair and the floor the resolution of Council was read by Dr. Robert Wilson, Secretary.)

DR. ROBERT WILSON (Reading) "That the Press Publicity Committee (that committee has previously been appointed consisting of the Executive Secretary, the Editor and the Secretary)—that that committee be authorized to investigate the employment of some person as a publicity representative on a part time basis to prepare and secure the publication of news and press releases of interest to the public and to the medical profession and that the council be authorized to employ such a person at an expense of not more than \$1200 a year."

THE CHAIR: Are there any questions about that resolution? Do I hear a motion of adoption the second time?

(The Motion was made by Dr. Wyman King and it was seconded by Dr. Crawford. There was no discussion. The vote was taken, the ayes had it and it is so ordered.)

THE CHAIR: I hope you will pardon me for having this unorthodox procedure but I thought we had passed over an important point a little bit too lightly and now there should be no question in the mind of anyone about the matter.

DR. GUESS: Mr. President, the fact that you felt called upon to do this thing that you felt to be unorthodox, brings this thought; in this last report there were a half dozen recommendations that we acted on in a group and by the time the last one was read most of us had forgotten the second one that was read. I would suggest to you that in the interest of information and intelligent action that as these reports are presented in the future, so far as the other reports are concerned, that we act on each individual recommendation as it is presented and then if we see fit adopt the report as a whole. I think that will make for a very much clearer idea of the delegates as to what they are acting upon.

THE CHAIR: That is an excellent point and we will follow same. Do you think it would be necessary to return to the report given us by Dr. Crawford?

DR. GUESS: I don't think so, in my personal opinion I don't think so, unless some member of the House of Delegates feel we should go back and pick

up these individual things. We have some important things coming up, things that are very important.

THE CHAIR: We will proceed with the reports of the Reference Committees. Dr. Goldsmith, *Chairman of the Committee on Amendments Constitution and By-Laws*, will give his report.

DR. GOLDSMITH: The committee members met yesterday afternoon and considered the things that were brought before us. The first one was presented by Dr. Weston and involved the addition of a section to Chapter VII of the By-Laws. First I would like to read to you this last paragraph of the By-Laws, *Chapter XIII, "Amendments"* (Reading) "These By-Laws may be amended by a two-thirds vote of the delegates present."

Dr. Weston presented this as a continuation of SECTION VI, CHAPTER VII: (Reading Dr. Weston's recommendation) "In the event any elective officer resigns, dies, move out of the State or is incapable of carrying out the duties of this office, then Council shall appoint qualified person to fill same. This selection may be approved by 2/3 vote of members of Council."

Mr. President, we changed that to read like this. (Reading)

CHAPTER VII, By-Laws, Section 6, Paragraph 2. "In the event any duly elected officer resigns, dies, moves out of the state, (S. C.) or is incapable of carrying out the duties of the office, then Council shall appoint a qualified member to fill such office."

Mr. President, the Committee on Constitution and By-Laws recommends the adoption of the above.

(This recommendation was seconded by Dr. Weston. It was requested that the recommendation be read again, and it was repeated by Dr. Goldsmith. There was no discussion, the vote was taken and passed and it was so ordered.)

DR. JOE CAIN: (Recognized) You didn't give me quite time to get up there. I wanted to ask one question, the resolution, as presented, had reference to elective officers, how about appointed officers, appointed by the Governor and nominated by our Association? That has given us a great deal of trouble and should be included in that to clarify the situation all the way through.

THE CHAIR: Do you move that that be added to this motion?

DR. CAIN: Yes, I would like to move that in addition to the phrase "Elected officers of the association" that it also include officers who are appointed by the Governor but who are nominated by the Association.

THE CHAIR: Dr. Goldsmith, will you accept that amendment?

DR. GOLDSMITH: As Chairman of this Committee I second that. (The motion was also seconded by Dr. Adeock, and discussion was called for.)

DR. GEORGE JOHNSON, of Spartanburg: I think it is a good idea. I don't know whether we legally can do that. It might be all right with us but how does the Governor feel about it?

DR. JOE CAIN: I have no fault to find with the resolution but from a practical standpoint, as a member of Council we have just recently had this thing come up with regard to a Member to the State Board of Medical Examiners. From time to time we have been asked to nominate members to this Board and to other offices, which the association is supposed to nominate and who are then appointed by the Governor, instead of being elected officers of our association. My point is to clear any confusion in the future—that an additional phrase be added so that the council can also nominate to the Governor for his appointment, as well as select elective officers to the association, in case of absence or in case of death or in case the office is not taken. That is the purpose of my motion.

THE CHAIR: Do you have any further discussion of this motion?

DR. GEORGE JOHNSON: I would like to ask Mr. Meadors if he thinks that can legally be done, if that is all right.

THE CHAIR: (To Mr. Meadors) Do you think that would stand up?

MR. MEADORS: Yes, sir, I think the statute says the officers, the officials shall be elected by the House of Delegates of the South Carolina Medical Association. I think any manner in which the South Carolina Medical Association desires to choose that man, would be accepted. Heretofore, you have been doing that through the House of Delegates, if you wish to extend that right to Council, I think it will be perfectly all right under the law.

MR. GOLDSMITH: A part of this is not quite constitutional. The stating of individual officers occurred under the Constitution. The Constitution can't be changed by a 2/3 vote, it must lay on the table a year. The procedure of election comes under by-laws. The name of "officer", I don't know if that can be included in this particular motion or not.

THE CHAIR: Mr. Meadors, will you help us on this?

MR. MEADORS: I will have to take a look at the by-laws first before I can answer the question.

THE CHAIR: I believe this is definitely a by-law change and not a constitutional change, but I would like to have Mr. Meadors opinion.

MR. MEADORS: I think it is a part of the by-laws.

THE CHAIR: Mr. Meadors' opinion is that this is a change in the by-laws, not in the constitution, and consequently it can be approved by a 2/3rds of the delegates present and voting.

DR. GOLDSMITH: Since that ruling has been made I include it in my original report and so move.

(DR. WESTON seconded the motion, there was no further discussion, the vote was taken, the ayes had it and it was so ordered.)

DR. GOLDSMITH (Continuing with his report) In the report of Council there were two or three things referred to this Committee and one of them was about the vacancy in the House of Delegates to the A.M.A. Under CHAPTER IV, of the By-Laws, Section 2, the committee recommends as follows: (Reading)

"Since there is a vacancy from the number of Delegates from S. C. Medical Association to the House of Delegates of the A.M.A., the committee on Constitution and By-Laws recommends the election of a Delegate for the remainder of 1954."

(This motion was seconded by Dr. Weston, Jr.)

THE CHAIR: I am going to ask Dr. Goldsmith to read his second recommendation in this instance because the two are intimately associated and you will have to vote on the motion separately but I think he should bring the next matter to the attention of the House of Delegates.

DR. GOLDSMITH: The second part of this Chapter IV, of the By-Laws, with a new added Section II, Para. 2, (Reading) "In order to stagger the terms of delegates to the House of Delegates of the A.M.A., at least one delegate be elected each year to serve for two years."

I can't recommend the adoption of that until the first one is voted on.

THE CHAIR: You recommend the passage of the first portion.

DR. GOLDSMITH: Yes, sir.

(This motion was seconded by Drs. Adcock and Weston, Jr., there was no discussion, and the vote appeared to be unanimous, and it is so ordered.)

(DR. GOLDSMITH rereads the second part of CHAPTER IV, found on Lines 16-18, inclusive, above)

I move the adoption of that recommendation.

(This motion was seconded by Dr. Weston, Jr.)

THE CHAIR: Is there any discussion?

DR. WESTON, JR. Mr. President, in view of the fact that these are amendments to the By-Laws don't you think it would be wise to have a show of hands rather than by voice—either hands or standing?

(There was no further discussion, the vote was taken by raising the right hand. The vote was unanimous again and it was so ordered.)

DR. GOLDSMITH (Continuing Report)

The third thing brought up under the report of Council I will read it to you so that you will know what it was. (Reading from report of Council) "The elevation of Dr. Julian P. Price to the Board of Trustees of the American Medical Association was noted. In recognition of the honor thus brought to our association, a motion was made and adopted by Council to suggest to the House of Delegates a change in the By-Laws of the Association to provide that any Trustee or other official of the A.M.A. automatically become an ex officio member of the Council of the South Carolina Medical Association."

That involves a change of the Constitution, we could not make any recommendation. Council suggests it, but it is under the Constitution. However, I think one member will oppose just such a change.

MR. WESTON: I move the adoption of the resolution as a whole. (This is seconded by Dr. Adcock.)

THE CHAIR: Is there any discussion?

DR. JOE CAIN: I would like to ask what disposition will be made of the last suggestion? Is it recommended that it will be laid on the table for action next year?

THE CHAIR: Do I hear a motion that we lay this on the table for consideration next year?

DR. WM. WESTON, JR.: I move we accept this report as a whole.

THE CHAIR: Do I hear a motion we lay this change of the constitution on the table until it can be voted on?

DR. JOE CAIN: Doesn't it have to be in writing?

DR. WM. WESTON, JR. It is in writing (handing up the motion to amend the Constitution.)

THE CHAIR: It is in writing, all in favor of placing this amendment to the Constitution, in writing, on the table for a year, please say "aye."

(This motion was passed and it was so ordered.)

A DELEGATE: (Recognized) Read it, we don't know what we are voting on.

THE CHAIR: I am going to blame this on my secretary, he came over there and distracted my attention during the last part of Dr. Goldsmith's report.

Here is a copy of the amended Constitution, ARTICLE VI, "COUNCIL—Any member of the South Carolina Medical Association holding a high office in the A.M.A. shall be an honorary ex officio member of Council without voting privilege during the term of his office."

THE CHAIR: You have already passed this, I guess we had better vote on it again. Do I hear a motion it be laid on the table?

(This motion was made by Dr. Cain, it is duly seconded there was no further discussion, the vote was taken and the motion passed and it was so ordered.)

THE CHAIR: We will now have the report of the Committee on Insurance, Blue Cross and Blue Shield, Dr. Joe Cain, Chairman.

(The Report is read by Dr. Cain)

Para. (a) Page I, of report. (This recommendation was put into motion by Dr. Adcock, seconded by Dr. Wyman King, there was no discussion, the vote was taken passed, and it was so ordered.)

Para. (b) Page I, of report (Motion was made re-

garding this recommendation by Dr. Weston, seconded by Dr. King.)

THE CHAIR: Is there any discussion?

DR. LATIMER: Who is going to handle the group insurance and the group pension plan, the secretary, the Council, or who? Who is going to put it into effect?

DR. JOE CAIN: Dr. Latimer, that is one of the reasons why I think the report should be read through to its conclusion before we take up the individual recommendations. When and if the first recommendations are adopted the committee intends to request that the House of Delegates retain an insurance committee to work with Council in putting these plans into effect. That is the last recommendation.

(There was no further discussion. The vote was taken on Recommendation, Para. (b), Page 1, of the Report, the vote was taken and passed and it was so ordered.)

THE CHAIR: Dr. Cain thinks probably, in this case, we could do this report more expeditiously by reading the whole report and adopting it as a whole or the separate recommendations. In this case we will vary the procedure and read all the recommendations at this time.

DR. CAIN: After I read them all if you feel that they should not be adopted, as a whole, we will take them up one at the time.

(The report of Committee on Insurance was read by Dr. Cain, through the middle of page 3—ending with the words "to act on the approval of council.")

DR. CAIN, Chairman: Mr. President, I move the adoption of the recommendations which have not already been adopted.

THE CHAIR: Dr. Cain, you do not provide any method for selecting or appointing this committee,—I would like some suggestion, do you want the incoming president to appoint it or it be elected by the House of Delegates, or how do you want it arranged?

DR. JOE CAIN, Chairman: The idea was that the present committee be retained—but since we already have such a committee in existence, but that such committee be continued, either appointed by the President, that is the way the present committee came into existence.

THE CHAIR: You have heard Dr. Cain's recommendations,—first of all, I would like to ask if you would like to pass on them separately, or collectively. If there is no objection to passing on them, on the whole, I will. Do I hear a motion that they be adopted in toto?

(The motion was made by Dr. Joe Waring, seconded by Dr. Pressly, there was no discussion, the vote was taken and passed, and it was so ordered.)

DR. JOE CAIN, Chairman: Gentlemen, that is all of the recommendations, however there is more to this report. The Committee has instructed the Chairman to bring one or two points before the house.

The first one concerns Blue Cross and Blue Shield. We would like to again remind you that the success not only of the Blue Cross and Blue Shield but of any insurance, which is sold to our patients, depends on the proper cooperation between the doctor and the patients. We can either kill it or we can allow it to thrive and become a good thing.

One of the biggest objections that we find in commercial insurance companies is the restrictions which they place, the time limits which they place on it, the limits which they put on coverage, which sometimes does not cover the ordinary experiences; and the reason most of them have these restrictions in their policies is that the actuarial experience in it is so poor that they can not afford to do it.

Now, if we are all absolutely honest in putting our patients in the hospital and the patients were absolutely honest in not wanting to go to the hospital,

except when necessary, I believe we would find a change in the disposition of most all companies to be more liberal. I think that is the main thing that we must keep in mind concerning hospital insurance, that if we treat it fairly the chances are it will come back to us in the value of better contracts and more coverage. If we do not treat it fairly the coverage will decrease and the prices are going to rise because not only is Blue Cross and Blue Shield having difficulty but the commercial companies do also. We would like to reemphasize that, it was brought out yesterday and brought out this morning by Dr. Broekman, and our committee wishes to reemphasize it at this time.

(Continuing to read his report—and reading on to end.)

THE CHAIR: Do I hear a motion that we approve this report as read?

(Motion was made that the report not only be approved as read but that this Body express its deep gratitude to the special committee which has been working since the last meeting of this House on this whole insurance problem, and Dr. Cain as Chairman of the Reference Committee for having gone into this subject, which is of such importance to us. This motion was seconded.)

THE CHAIR: Is there any discussion?

DR. B. J. WORKMAN, of Woodruff (Recognized): I think Dr. Cain should be commended for his report on malpractice insurance. I speak feelingly, especially as one having sat in the hot seat one time, having been sued for One Hundred Thousand (\$100,000) Dollars, the amount of which I was very much flattered by. I think a doctor must be fair to himself. If you are sued and you feel deep down in your heart you are right, you ought to stand up and fight, if you feel you are not guilty. This thing of trying to settle out of court for fear of public opinion, there is nothing to it. I think Dr. Cain should be commended on this report.

DR. FINGER: (Recognized:) Mr. President, I can attest the fact it is hard to get this type of coverage. I have never had a suit, nor do I know of anybody in the Pee Dee Section who has had a suit. Perhaps a few settled out of court, however, there is a general feeling by most insurance companies that they are getting stuck and it is more or less on a national basis, now, and rates are prorated on the fact that in the north and in certain other sections of the country it is quite popular to sue physicians. The thought occurred to me sometime ago when there was a period I was not covered, because of this hesitancy of the companies to cover me, that perhaps the Association should consider self insurance as a group.

I think our experience rating in South Carolina would be considerably better than that over the nation. And if this Insurance Committee, that has done such a commendable job would discuss the feasibility of this, with the S. C. Insurance Commission in the event that the difficulty gets greater in the future, we would be prepared, perhaps to enter into some sort of self-insurance plan, pretty much as our Hospital Service, but as it pertains to the organization in malpractice insurance.

THE CHAIR: Thank you Dr. Finger.

DR. CAIN: With reference to Dr. Finger's remarks, I would like to pass this information on—that at the present time I think for \$1000 insurance I pay \$80 or \$90 a year. Suppose there are one thousand members of the State Association who pay \$90 a year, we would have Ninety-Thousand (\$90,000) Dollars and if one of us got sued for \$100.00 we wouldn't have enough to pay it to start with. I am of the opinion after studying this, our Committee came to the conclusion that if one of the large insurance companies or all of them are not in favor of this type

of business that we would be doing well likewise to shy clear of it.

THE CHAIR: Is there any discussion on Dr. Guess' motion, any further discussion?

(There was no further discussion; the vote was taken and the motion passed and it is so ordered.)

THE CHAIR: I want to thank you, Dr. Cain for this excellent report.

THE CHAIR: The next on the agenda is the *Report of the Committee on Miscellaneous Business*, Dr. W. L. Pressly, Chairman.

DR. PRESSLY: Your committee had three resolutions: No. 1, a continuation of \$500 a year for the publication of the History of Medicine in South Carolina. As you recall, last year the Council contributed \$500 to be deposited against the time that this publication should come out and we recommend that we continue \$500 a year as the approximate cost of this publication will be around Three Thousand (\$3000) Dollars. We recommend that.

(Motion was made by Dr. Waring that the recommendation be adopted; this was seconded by Dr. Adcock; there was no discussion, the vote was taken, the motion passed and it was so ordered.)

Dr. Pressly: Second, the Committee goes on record as being opposed to the Tennessee Plan—that is veterans' care. All of you are familiar with the Tennessee Plan—it is sponsored by Dr. Shoulders and we go on record as opposing this plan.

(Dr. Weston, Jr. moved the adoption of this recommendation, it was seconded, there was a call for discussion)

QUESTION—From the Floor—What is the Tennessee Plan?

DR. PRESSLY: I thought everybody had read it. The Tennessee Plan, it is the Plan of medical care of veterans and their families from the cook up and down and covers everything. Dr. Weston is thoroughly familiar with this Plan, since we have recently discussed it, Dr. William Weston, Jr., would you like to explain the Plan.

DR. WILLIAM WESTON, JR. I would like to make only one remark, it is an unexplainable condition that Dr. Shoulders has just reversed himself; he used to be opposed to it. He didn't get anywhere with the plan he had, so he has changed and called it the Tennessee Plan and reversed his position so as to give everybody from A to Z the privileges of the Veterans Administration and the Veterans' Hospital, in fact anyone who has had any service of any kind with the U. S. Government, to be treated by the Veterans' Administration. It is folly.

THE CHAIR: I would like to add to that that it does not have to be a service-connected sickness or injury, it can be non-service-connected and it also covers dependents.

DR. WESTON, JR. Everybody, from A to Z.

THE CHAIR: It covers practically everybody. I understand about 80,000 veterans are leaving the army each month and at that rate it would soon blanket the country. Are you ready for the vote?

(The motion which had been previously made and seconded was voted on, passed, and it was so ordered.)

DR. PRESSLY, Chairman (Continuing) There was one other report involved, that of the Cancer Control Committee. We just want to go on record as commending this committee for their excellent work done in behalf of cancer control.

THE CHAIR: Do I hear a motion that we accept and approve this last recommendation?

(Dr. Weston, Jr., so moved, which motion was seconded by Dr. Cain, there was no discussion, the vote was taken and passed and it was so ordered.)

DR. FINGER (Recognized) It is the proposal that

the representatives will be advised of our censorship of the Tennessee Plan?

THE CHAIR: That was not included in the motion but if you wish to make such a motion.

DR. FINGER: I think it would be quite impotent unless we did so move. My motion is that all of the representatives and senators of the State of South Carolina be advised of Dr. Pressly's Committee's recommendation, relative to the Tennessee Plan.

(This motion was seconded by Dr. Weston, Jr.)

THE CHAIR: Do you wish to discuss the question?

DR. GOLDSMITH: I don't think that can be handled that way because this has not been acted on by the American Medical Association yet, therefore there is nothing definite that we can present to our congressmen or senators. It is to come to the House of Delegates of the A.M.A. in June and I think it would be rather out of order for us to instruct our congressmen or senators. I neither think it wise to instruct our delegates to the A.M.A. yet. They have sense enough to vote for themselves.

DR. WESTON, JR. (Recognized) Dr. Baker, I would like to tell Dr. Goldsmith and others that Congress does not wait for A.M.A. to act.

THE CHAIR: Is there any further discussion of Dr. Finger's motion?

(There was no further discussion, the vote was taken and the motion passed, and it was so ordered.)

(Announcement made by The Chair that the members of the Mediation Committee of the S. C. Medical Association will meet following the election of officers at approximately 1:00 o'clock.)

These are Dr. Roderick Maedonald, Chairman, Dr. Weston Cook, Dr. Keith Sanders, Dr. R. B. Seurry, Dr. W. R. Tuten, Dr. Jim Sanders, Dr. Walter Mead, and Mr. M. L. Meadors, also Dr. John Siegling, Secretary.)

THE CHAIR: Does anyone think of any further business to come before the house at this time?

(The election of officers having been set for noon, the meeting of the House of Delegates was recessed until noon, the Chair urging all to be back in their seats promptly at 12:00 o'clock.)

12:00 o'clock—May 12th—1954, ANNUAL ELECTION

THE CHAIR: The meeting will come to order. The Chair will entertain nominations for the office of president-elect of the S. C. Medical Association.

DR. WM. WESTON, SR. (Recognized) Mr. President, Members of the House of Delegates, it is a great pleasure as well as a great privilege to recommend and nominate a man whom you know well, a man who has been most diligent in the performance of every duty which he has been called upon, not only in a state-wide capacity but in a local capacity, as well. He is a man of learning, dignity and strictly ethical in every respect. It gives me great pleasure to nominate Dr. O. B. Mayer, of Columbia.

THE CHAIR: Dr. O. B. Mayer of Columbia has been duly nominated, do I hear a second. (The nomination received several seconds from the floor.)

(Motion was made by Dr. Hope that the nominations be closed and that the Secretary cast a unanimous ballot for Dr. Mayer; this received several seconds; this motion was voted on by a show of hands, which appeared to be unanimous; Dr. Wilson, Secretary was instructed by The Chair to cast the unanimous vote for Dr. O. B. Mayer; this was done amid applause. Mr. Meadors was requested to conduct Dr. Mayer to the rostrum, where he was met by President Baker.)

THE CHAIR: Benny, it is a great pleasure for me to introduce you at this time, although you are well-known to them. Are you not a grandson of a past president of this organization?

DR. MAYER: My father was president.

THE CHAIR: It gives me great pleasure to introduce Dr. O. B. Mayer.

DR. O. B. MAYER: Mr. President, members of the Association, I am duly grateful to you for this high honor. As your President-Elect I shall try during the coming year to prepare myself for the duties ahead. I recognize its responsibility and I recognize the traditions of our association. I hope with your help that I can carry on. I thank you.

THE CHAIR: The Chair will entertain nominations for the office of Vice-President.

DR. RODERICK MACDONALD: I place in nomination the name of Dr. J. Claude Sease of Newberry, a faithful member of this association for many years.

(This nomination was seconded by several; Dr. Callison moved the nominations be closed and that a unanimous ballot be cast for Dr. Sease; this motion was seconded, voted on and passed; and the Chair directed the Secretary, Dr. Wilson to cast a unanimous ballot for Dr. Sease.)

(The Chair requested Dr. Sease to stand and their was hearty applause as Dr. Sease stated this was a miscarriage of judgment.)

OFFICE OF SECRETARY—Dr. Robert Wilson, Jr. of Charleston was nominated to succeed himself, this was seconded by Dr. Joe Waring; motion was made by Dr. Evatt that the nominations be closed and that the Secretary cast a unanimous ballot for himself; This motion was voted on and after being duly seconded was unanimously passed; and the Chair directed the Secretary, Dr. Robert Wilson, Jr. to cast a ballot for himself. This was done amid applause.)

THE CHAIR: Dr. Wilson has been duly elected as secretary.

OFFICE OF TREASURER

THE CHAIR: I believe that the Treasurer has to be nominated by Council and Council has nominated Dr. Howard Stokes of Florence to succeed himself. (This nomination was seconded by Dr. Wyman King; motion was made by Dr. Callison that the nominations be closed, the motion was seconded, the vote taken and passed.) Mr. Secretary, you can perform your duties again, Dr. Stokes has been duly elected. (Dr. Stokes at the request of the Chair stood up for recognition and received hearty applause.)

DELEGATE TO A. M. A.

THE CHAIR: The next is the election of a delegate to A.M.A. Let me explain, you know, under this we are going to have to have two elections, and the first of the elections is for the unexpired term of Dr. Julian Price who will be in office from now until January 1, 1955. Do I hear a nomination?

(Dr. Robert Wilson, Jr. was nominated; this was seconded by Dr. Wm. Weston, Sr.)

DR. ROBERT WILSON, JR. (Recognized): I would prefer not to be a delegate to A.M.A. if the nomination can be withdrawn. I served as alternate, I feel definitely we should divide up some of the jobs and positions, and I go once a year as Secretary, anyway and if the doctor will withdraw the nomination I would prefer not to be nominated as a delegate.

DR. WESTON, SR. (To the Chair) Will you rule his objection out of order?

THE CHAIR: Thank you Dr. Weston.

DR. GRESSETTE: I would like to nominate Dr. George Truluck to fill this unexpired term of delegate to A.M.A.

DR. PRICE, JR.: (To the Chair) You stated that Dr. Price's unexpired term is to be filled, that would be the end of 1955. What we are trying to do is stagger it so that we will elect somebody to fill out this year and it will expire January 1, 1955.

THE CHAIR: I said January 1, 1955, that we are now electing someone who will hold office from now to January 1, 1955.

The next recommendation will take care of staggering the situation.

DR. GOLDSMITH (Recognized) That particular thing was covered in our report from the by-laws committee this morning, so that this first one is now for the balance of 1954.

DR. GASTON, of Chester: Dr. George Dean Johnson of Spartanburg has been duly nominated. (That is seconded by Dr. Workman—also by Dr. Robert Wilson.)

(Motion was made that the nominations be closed; this was seconded, voted on and passed, it was so ordered.)

THE CHAIR: Dr. Robert Wilson, Jr., Dr. George Truluck and Dr. George Johnson have been nominated, we will have to cast secret ballots. I would appreciate it if you would prepare your ballots as quickly as possible and turn them into the tellers.

DR. D. L. SMITH (Recognized) A point of order, has Dr. Wilson's nomination been withdrawn or not?

THE CHAIR: No, sir.

TELLERS APPOINTED BY THE CHAIR: (Dr. D. L. Smith and Dr. Dave Adcock)

(While the tellers were counting the votes for Delegate to A.M.A., nominations were made for Councilor from the 1st district, Dr. Bachman Smith being nominated by Dr. Hope and this was duly seconded)

DR. GOLDSMITH (Recognized) I would like to rise to a point of order. I believe that this is out of order to jump from one section of the election to something else, because the men over there (the tellers) are not given an opportunity of learning what is going on and a chance to vote, and I think something like this is out of order.

THE CHAIR: I do not believe this could be done without a unanimous vote.

DR. CALLISON: (Recognized) Mr. President we should have a report of the Credentials Committee.

THE CHAIR: Eighty-eight members are eligible to vote, that was handed to me by Dr. Cantey.

THE CHAIR: (Receiving report from teller, Dr. Adcock) The result of this election for Delegate to A.M.A. is Dr. Johnson is elected. He has a full majority of the votes.

DR. HANCKEL: (Recognized) As I understand it, his term of office will expire January 1, 1955 or December 31, 1954?

THE CHAIR: He is elected for seven and one-half (7½) months, his term expires January 1, 1955.

DR. HANCKEL: As I understand it, also it is in order at this time to put up for nomination an individual to carry on for the next term of office, is that true?

That motion hasn't quite been made but I will now make it.

DR. WILSON (Recognized) I would like to nominate Dr. George Dean Johnson for the two (2) year term beginning January 1, 1955. (This nomination was seconded by Dr. Hanckel)

DR. GOLDSMITH (Recognized) I would like to place in nomination the name of Dr. Charles N. Wyatt, of Greenville, for the two year term beginning January 1, 1955.

(This nomination was seconded by Dr. Edwards)

(Motion made by Dr. Snyder that the nominations be closed, this was seconded by Dr. Josey; the vote was taken on this motion and passed, and was so ordered.)

THE CHAIR: We will now cast written ballots for Dr. George Dean Johnson and Dr. Charles N. Wyatt. (Tellers report) Dr. Johnson has been elected to succeed himself on January 1, 1955.

ALTERNATE DELEGATES—A.M.A.

DR. BARRON: (Recognized) I would like to nominate Dr. Robert Wilson, Jr., as alternate. This

nomination was seconded by Dr. Adeock; Motion was made that nominations be closed, this was seconded, the vote was taken and unanimously passed.

THE CHAIR: Dr. Wilson, you have been duly elected. Do you want to cast your ballot for yourself, again?

Now, there is one more alternate to be elected. I would like to hear a nomination for an alternate to be elected for one (1) year, Delegate to the A.M.A.

(The name of Dr. Charles N. Wyatt was placed in nomination, this was seconded by several people; a motion was made that the nominations be closed, this was duly seconded; voted on and passed and it was so ordered.)

THE CHAIR: I will instruct Dr. Wilson to cast a ballot for Dr. Charles N. Wyatt, he has been duly elected.

COUNCILORS—(3 year terms)

THE CHAIR: Do I hear a motion for Councilor for the 1st District (the term of Dr. J. W. Chapman has expired)

DR. HOPE: I nominate Dr. Bachman Smith. I had previously nominated him, and it has been duly seconded.

(Motion was made by several that the nominations be closed; this was seconded by Dr. Thackston and others, the vote was taken and passed and it was so ordered.)

THE CHAIR: Dr. Wilson cast a unanimous ballot for Dr. Bachman Smith, duly elected Councilor from the First District.

COUNCILOR—2nd District.

THE CHAIR: Dr. O. B. Mayer, our new President-Elect was Councilor from the 2nd District. A councilor will have to be elected to fill the unexpired term of Dr. O. B. Mayer.

DR. WYMAN KING (Recognized) I would like to place in nomination the name of one of our most distinguished surgeons, a man who has served his profession very ably and who has been a member of the Board of Trustees of the Medical College for a number of years; a man who is respected by all who have the privilege of knowing him, Dr. A. F. (Smiley) Burnside. (There was a volley of seconds to this nomination.)

DR. DICK JOSEY (Recognized by The Chair) I put in nomination the name of Dr. George McCutchen, also a surgeon, and a good man.

THE CHAIR: Since he is a surgeon and a 'good' man, do I hear a second to that nomination.

(Dr. McCutchen's nomination was duly seconded. Dr. Morgan made a motion that the nominations be closed, this was seconded, voted on and passed)

THE CHAIR: Prepare your ballots for Dr. Burnside and Dr. McCutchen. (Receiving the report of the tellers) Dr. Burnside has been duly elected to succeed and to complete the unexpired term of Dr. O. B. Mayer.

(Dr. Mayer stated that there was one year to be served)

COUNCILOR—FOURTH DISTRICT

THE CHAIR: Do I hear nominations for councilor from the 4th District, the Term of Dr. C. N. Wyatt expires.

DR. LATIMER (Recognized) I nominate Dr. Wyatt to succeed himself. (This was seconded by Dr. Edwards; Dr. Wilson moved that the nominations be closed; this was seconded by Dr. Adeock and several others; the vote was taken, it was passed and it was so ordered.)

THE CHAIR: Dr. Wilson will you now cast a ballot for Dr. Wyatt, he is duly elected.

COUNCILOR—SEVENTH DISTRICT

THE CHAIR: The term of Dr. A. C. Bozard expires, do I hear a nomination for Councilor from the 7th District?

DR. SNYDER: I move that Dr. Bozard succeed himself. (This was duly seconded)

DR. TILLER: I nominate Dr. Samuel E. Miller of Georgetown. (This nomination was seconded)

THE CHAIR: There being no further nominations prepare your ballots for Dr. A. C. Bozard or Dr. Samuel Miller. (Receiving report from tellers) Dr. Bozard has been duly elected to succeed himself.

MEMBERS—MEDIATION COMMITTEE (3 year terms)

THE CHAIR: The next election is for the members of the Mediation Committee. There will be no nominations because they have already been named by Council. (These names had already been placed on the black board) Prepare the three sets of ballots at one time so that we can count them quickly.

(After getting report from the tellers)

Dr. John Siegling, has been duly elected to succeed himself from the 1st District.

Dr. Goldsmith has been elected to succeed himself from the 4th District.

Dr. Norman Eaddy of the 7th District has been elected. So three new members of the Mediation Committee have been duly elected.

STATE BOARD OF MEDICAL EXAMINERS—4 year terms. 4th District.

THE CHAIR: There are three to be elected, the first one is the 4th District, Dr. George R. Wilkinson's term expires)

Dr. Goldsmith (Recognized) I would like to nominate Dr. Wilkinson to succeed himself; (this motion was duly seconded; motion made that nominations be closed; this was seconded; the vote was taken and passed and it was so ordered)

THE CHAIR: Dr. George R. Wilkinson has been elected to succeed himself.

5th District

THE CHAIR: The term of Dr. Carl A. West has expired by resignation and he will not allow his name to be considered for renomination, I understand.

THE CHAIR: Do I hear any nominations for Councilor for the Fifth District?

Dr. Roderick Macdonald was nominated from the floor; this nomination was seconded; Dr. Hope moved the nominations be closed; this was seconded by Dr. Wm. Weston, Sr., the vote was taken, passed and it was so ordered. The ballot was cast by Dr. Wilson.

8th District

THE CHAIR: The term of Dr. W. R. Tuten expires, do I hear a nomination?

DR. PREACHER (Recognized) I would like to nominate Dr. W. R. Tuten to succeed himself.

This nomination was duly seconded, a motion was made that the nominations be closed and that the secretary cast a unanimous ballot for Dr. Tuten; this was seconded by Dr. Wm. Weston, Jr., the vote was taken and passed and it was so ordered. Dr. Wilson cast a unanimous ballot for Dr. W. R. Tuten.

HOSPITAL ADVISORY COUNCIL TO STATE BOARD OF HEALTH (4-year term)

THE CHAIR: The term of Dr. L. Emmett Madden expires—do I hear a nomination for this position?

DR. CALLISON: I nominate Dr. H. F. Hall of Columbia. (This was seconded.)

DR. GUESS: I nominate Dr. W. C. Cantey, of Columbia. (This was seconded.)

(Motion made that nominations be closed, duly seconded; voted on and carried.)

THE CHAIR: Prepare your ballots for Dr. Cantey or Dr. Hall. (Receiving report from tellers) May I announce the result of the last ballot, which is for the election of the Hospital Advisory Council to the State Board of Health, Dr. Cantey was elected.

THE CHAIR: Last year council appointed a committee to get some information relative to the Medical Association having its meeting on a boat, having a

cruise to some nearby point for a short number of days. Dr. Harry Davis was Chairman of this Committee. He has the information available on this subject. I would like to hear from Dr. Davis at this time.

DR. DAVIS: As Dr. Baker has told you, Dr. Hanckel, Dr. Walker and myself were appointed to this committee. Several travel agencies have been interviewed and a suitable vessel can be obtained to sail from Charleston to Havana, Bermuda or both. The cost will be the minimum of \$20 per person, per day, an average of \$30 per person per day, this will include all services with the exception of tips and personal expenses such as beverages. While in port the ship will be used as your hotel. The travel agency will furnish a reasonable number of complimentary fares for guests of the association. The Travel agency assumes all financial obligations in connection with the ship. They will print suitable literature and handle all details in regards to reservations. The Medical Association would not be financially involved in any way.

Our Committee Recommends:

1. That the Convention cruise be tentatively scheduled for 1956. For this reason: This will allow the travel agency representative to be present at the 1955 meeting, to accept reservations and display advertising material.

2. That a Committee be appointed to select both the travel agency and the destination of the cruise and plan a tentative itinerary.

Thank you.

THE CHAIR: Dr. Davis, do you suggest that this committee be appointed by the incoming president? That is what is customary.

DR. DAVIS: Yes, sir.

DR. HANCKEL: I would like to second Dr. Davis' recommendations. If his recommendations are not in the form of a motion I would like to put them in the form of a motion.

(This motion was seconded by Dr. Wyman King.)

THE CHAIR: I would like to hear some discussion about this proposal. If you think it advisable. Does anybody wish to discuss the matter.

Question (From the Floor) How many days would we be gone?

THE CHAIR: That would be determined by the committee, the committee will be appointed by Dr. Gaines and will have full authority to act.

MOTION (From the floor) I make a motion that we receive this as information until the next meeting.

DR. DAVIS: If it is to be done in 1956 it has to be passed at this time in order to have a representative here next year and get the information and make the plans for the succeeding year.

(From the Floor) There is already a motion before the House. Call for the question.

DR. WILSON: I think this matter requires a good deal of serious and long consideration before you reach any final conclusion. I think we should know the experience of the North Carolina group, the size of the boat, whether all members of the association, who can go, can be accommodated; the length of time and a great many other considerations. I am definitely opposed to settling this tentatively for 1956 at this time. I think it is a matter we ought to talk about and consider. We can talk with a great many people over the state and get more of their re-action, rather than rush into any precipitate decision at the moment.

THE CHAIR: Any further discussion. There is a motion.

DR. GAINES: I wonder if some expression by standing or hands could be given to let us know how many would be interested in this thing. It would be worth something for the committee to know how the delegates feel about it, whether or not enough would be interested.

THE CHAIR: There is a motion before the house.

DR. DAVIS (Recognized) Let me state in setting this thing tentatively for 1956 it does not in any way make us take it. It is not mandatory that we take the cruise, the travel agency merely wants to do some planning, when you set a tentative date—they will send cards out to you members, telling you something of the plans, and asking if you are interested. When they receive the cards, this will give an idea of the number who will probably go on this cruise and their representative will come to our next meeting, they will have literature and at that time you can decide if you are going.

In answer to someone's question, the proposed cruise was five days.

(Someone from the floor asked "Where will you find a golf course on this boat?")

THE CHAIR: Dr. Hanckel, you made the original motion, would you please give it to them once more. They did not understand it.

DR. HANCKEL: My motion was simply that we accept the recommendations of the Committee, of which Dr. Davis was the Chairman. The recommendations stated that we select a committee who would have the authority to gather further information and select a travel agency, which travel agency would be present at the next meeting of the association; and in the meantime this travel agency would go about ascertaining the number of doctors who would be interested in going on such a cruise and would have full information present and assembled for this committee's report at the next meeting. And, Dr. Davis has pointed out it isn't mandatory that we rush into a "precipitate decision", as Dr. Wilson has stated in the matter of selecting a place for 1956.

THE CHAIR: If you boil it right down, your motion is that we appoint a committee to thoroughly investigate this matter and report back to this body next year, that is what it amounts to?

DR. HANCKEL: Yes, sir, the travel agency—this committee has the privilege of selecting a travel agency who will gather information and be here with it next year.

THE CHAIR: That motion was duly seconded, is there any further discussion?

(The vote was taken, apparently unanimous, there were no "noes". It was decided to have a vote by hands.)

44 were in favor—10 opposed.

THE CHAIR: The motion is carried. As I understand it, this doesn't bind the meeting of the House of Delegates as regards the 1956 meeting place. The information will be available next year and in the meeting in May 1955 we will decide where the meeting will be in 1956 and whether it will be a cruise.

DR. GAINES (Recognized) I wonder if the information would be of some value to the incoming committee to be appointed if you know how many here were interested in taking this cruise. How many members of this group, just so they are members of this association, here present in this room would be possibly interested in a cruise for 1956. Please raise your hands.

(A number of hands were raised. That helps us out considerably.)

THE CHAIR: Do you want them counted?

DR. GAINES: No.

THE CHAIR: Now we will come to selection of a meeting place for the year, 1955.

DR. HOPE: I would like to extend an invitation on behalf of the Charleston County Medical Society for the meeting for next year, particularly, we would like it for the fact we believe the new medical college hospital will be completed by that time.

DR. DAVID ADCOCK: I move we accept his invitation.

DR. CALLISON: I second that motion.

THE CHAIR: Do I hear any other suggestions?

DR. J. N. GASTON (Recognized) I move we thank the Charleston County Society for their kind invitation and come back to Myrtle Beach next year.

THE CHAIR: Do I hear a second to that motion.

(There were several seconds)

THE CHAIR: Are there any further suggestions as to a meeting place? There being no further suggestions I will appreciate it if the tellers would count the votes once more—Charleston versus Myrtle Beach.

Let's have a hand on the meeting place, those in favor of Charleston, please raise your hands. (hands are raised) I don't see any need voting for the Myrtle Beach, as there are seventy in favor of having the

meeting in Charleston.

THE CHAIR: Two brief announcements:

The meeting of the new council will be held in the back of this room immediately following this meeting.

Newly elected officers will meet in this corner of the room to have photographs taken.

The scientific program will have to be postponed thirty minutes, we will meet again at 2:30 for the scientific program and the main speech of the evening will be at 4:30 P. M.

Do I hear a motion that the House of Delegates adjourn?

(Motion was made, seconded and it was so ordered)

ADJOURNMENT



DR. GAINES

DR. BAKER

DR. MAYER

(Photo by E. S. Powell)



DR. HOWARD STOKES, DR. THOMAS GAINES, DR. ROBERT WILSON

(Photo by E. S. Powell)



OFFICERS AND COUNCIL

1954 - 1955

Front Row: Drs. C. N. Wyatt, Thos. R. Gaines, O. B. Mayer, Jos. Cain, Robt. Wilson, C. R. F. Baker.

Back Row: Drs. J. I. Waring, J. H. Gressette, A. C. Bozard, A. F. Burnside, R. L. Crawford, H. B. Morgan, D. L. Smith, H. W. Stokes.

(Photo by E. S. Powell)

REPORT OF THE MEMORIAL COMMITTEE

Dr. C. J. Milling, Chairman

Mr. President:

Since our last convention twenty-seven members have left our ranks and have set out upon their journey across the Great Divide. They represent every section of the state and range in age from the vigorous prime of youth to the wise and hoary patriarch, weighted with the burden of years but rich with the wisdom of experience.

This roster of the dead is a roll of honor, the names of our colleagues who have fought the good fight and have gone ahead, a little way, before us. No doubt many of the older ones were happy to lay down their burden and grateful to accept the opportunity to rest. During their lives they had seen many changes, some taking place so gradually that, like old age, the transition had occurred before they were aware it was happening. In one generation medicine, once an independent, individualistic profession, has become a regimented craft union with smoothly working, but powerful control groups inspecting, directing, often rejecting and invariably collecting. The while it is attempting to raise its own standards by squeezing everybody into a series of perfectly machined molds, it is facing the greatest crisis of its life in fighting off the threat of government control. Because of a Communist inspired whispering campaign, the honored concept of the family doctor, typified by the immortal painting of Sir Luke Fildes, is rapidly being replaced by such harsh epithets as "money lover" or "Cadillac

cruiser."

Yes, the older brothers have seen many changes, and the aged seldom welcome change. Some, even, of those of us in mid-passage, feel a little frightened at what we observe, a trifle uncertain and insecure.

It is the young who have ever looked forward, rather than backward, who are not afraid of the picture. And it is therefore the young whom we most particularly lament. Among these names that I am about to call are those who questioned not the spirit of the times, for they were a part of that spirit, who were full of adventure and the zest of life, who said not, "Look what we have lost," but rather "Let's get going." After a long and costly preparation they were ordered by the Great Commander to be discharged from service. Why these orders so often come at unexpected and seemingly impractical times, we do not know, nor does it help to question or protest. We only know that they are with us no more; that here a familiar face is absent, a booming laugh or a hearty handshake gone forever.

And so, setting out together on the same mysterious journey, are some of the best of our young friends and the wisest and kindest of our old, with many a one in the middle decades and all hallowed by the presence of a saintly woman, the first of her sex to achieve the degree in South Carolina.

Mr. President, I give you a goodly company, and I shall read their names, and I move you, sir, that after I have read them, this assemblage stand, for a moment of silent and prayerful reflection, in their honor.

DECEASED MEMBERS

NAME	ADDRESS	DATE OF DEATH
McCollough, John H. (not previously reported)	Newberry	June 28, 1952
Folk, John Lucius	Fairfax	May 8, 1953
Hayne, James Adame	Congaree	May 11, 1953
Hoshall, Frank Adelbert	Charleston	July 2, 1953
Corbett, John Witherspoon	Camden	July 8, 1953
McCord, Ollie Hagan	Woodruff	July 25, 1953
Gregory, Lorenzo T.	Kershaw	July 28, 1953
Power, Eugent Logan	Abbeville	July 30, 1953
Settle, Herbert G.	Fort Mill	Missing since August 4, 1953
Kirk, Marion Singleton	Hagood	September 13, 1953
Fouché, James Sample	Columbia	October 11, 1953
Matthews, Duncan Newton	Columbia	October 15, 1953
Brooks, Thomas Gibson	Aiken	October 27, 1953
Fort, James Arthur, Sr.	North	November 15, 1953
Zerbst, George Henry	Columbia	November 21, 1953
Edenfield, J. Ryerson, Jr.	Graniteville	November 25, 1953
McCutchen, R. O.	Bishopville	January 5, 1954
Daniel, Homer M.	Anderson	January 14, 1954
Sparkman, Edward Heriot, Jr. Capt., U. S. Navy, Retired.	Charleston	January 21, 1954
Allan, Sarah Campbell	Charleston	February 25, 1954
Culbreath, Paul H., Jr.	Columbia	March 5, 1954
Rogers, Wilson Chalmers	Indiantown	March 8, 1954
Deas, Henry	Charleston	March 9, 1954
Stuckey, Theodore Malcolm	Bamberg	March 12, 1954
Boggs, Luther Watkins	Greenville	March 14, 1954
Moore, James H.	Whitmire	March 29, 1954
Woodruff, William A.	Woodruff	April 9, 1954

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain Mullins
J. D. Guess Greenville
C. J. Milling Columbia
H. R. Pratt-Thomas Charleston

Vince Moseley Charleston
Ben Miller Columbia
W. H. Pringleau Charleston

G. D. Johnson Spartanburg
R. M. Pollitzer Greenville
Hugh Smith Greenville
Walter Mead Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)
Subscription Price

Charleston, S. C.
\$3.00 a Year

AUGUST, 1954

How Dependable are Mortality Statistics?

In a recent annual maternal mortality report,¹ the state maternal welfare investigating committee revealed that only 69 per cent of the maternal deaths were reported through official channels. The other 31 per cent came to light principally through fortuity, and 13 per cent were discovered only after the committee matched the death certificates of all women between fifteen and forty-five years of age with the birth and stillbirth certificates for the same period, to see if a reportable birth had been registered under the name of the deceased within three months of death.

It is a sobering thought to consider the magnitude of this error and to realize that it probably exists on a nationwide scale. It is more sobering still to realize that even the above ingenious and formidable crossmatching method cannot expose maternal deaths in those women who die undelivered, or whose conceptus has not attained reportable age, or whose age placed them outside the arbitrary limits of the group crossmatched.

Inaccurate reporting thus undermines the validity of all comparisons in the field of maternal health, making it particularly difficult to estimate progress correctly and to rank the causes of maternal death properly. The solution lies in awakening a vital interest on this problem on the part of all doctors handling obstetric cases and in improving the laws governing the reporting of maternal deaths. A written answer to the question concerning pregnancy within three months of death should be compulsory on the death certificate

of all females as the first step in correcting the many erroneous reports arising from incomplete death certificates. This should be a matter of like concern to the practicing physician, the hospital administrator, the public health authority, and the legislators of each state.

Report of A Delegate to the A. M. A. in San Francisco

The most amazing feature of the House of Delegates is the amount of work transacted and the fairness with which all sides are heard. By the last day seventy-seven resolutions had been read either as a whole or by title, if similar to previous ones, and what took longer, the reports of the different councils and the Board of Trustees. Every report is referred to a reference committee and that is where the arguments become heated and the fur flies. Any doctor is allowed to talk fifteen minutes on the subject and a rebuttal or summary of five minutes. As an example, the Tennessee plan of Veterans care has been argued every year for several years by a previous president of the A. M. A., Dr. Shoulders. His argument is that the stand of the A. M. A. is unrealistic politically, therefore, we should compromise and give care to all veterans for all conditions. Every year he is heard respectfully, and every year the other side supported by the vast majority of physicians of the A. M. A. as well as the Association of American Physicians and Surgeons gives its argument. Some of the reports are long and tiresome and necessarily so because so much material must be covered. As monotonous as the procedure may become, the subject matter is always interesting.

The Speaker of the House is Dr. Reuling of

¹Minnesota Medicine 36:609, June, 1953.
From the BULLETIN of MATERNAL WELFARE—
March-April 1954.

Bayside, N. Y., and his assistant is Dr. Askey of Los Angeles. Both are good parliamentarians, of course, and are fair to everyone. Any delegate can introduce a resolution either from his State Association, his Medical Society, or as his own. Any doctor is at liberty to discuss the resolution when in reference committee.

Some of the topics discussed were: The question of rendering bills — each doctor should submit separate bills; Osteopathy—It was decided to ask the schools of osteopathy to allow a committee of doctors to inspect their schools and determine the best solution. Negro physicians—North Carolina each year tries to have the A. M. A. accept the negro Medical Society of North Carolina as an affiliate without any success. Membership for special groups of physicians—Interns and Residents who graduated from a certified medical school may have a membership in the A. M. A. at a nominal or no fee while in training.

Physicians under the "Doctor Draft Laws": The House of Delegates favored a resolution by the Board of Trustees after careful study requesting the Director of the Office of Defense Mobilization to defer if practicable the induction or involuntary recall of physicians during the second quarter of 1955 other than those liable under the basic selective service act.

Motor Car Safety: Safety belts and rigid steel protecting bars over the occupants were urged for automobiles. (It's twelve times safer per passenger mile to fly the commercial airlines than it is to ride in a car.)

There were many other subjects brought up such as the ethics of H I P plan in New York which advertises and in turn has a panel of doctors to which the patients who join this plan can go, or the Kaiser Permanente Plan. I have tried to mention only a few of the highlights. If there are any particular subjects that interests a reader "Bully" Weston or I can tell you whether it was brought up and how disposed of.

Julian Price is a highly respected and liked member of the Board of Trustees. The Board began its all day meetings Wednesday before the House of Delegates started Monday. They

even meet at night usually on serious business. Julian is also one of the founders of the Aces and Deuces Club composed of delegates from states and territories that have only one or two delegates. Its purpose is purely social. The large delegations give light snack luncheons and usually keep open house. This Club is the only way we of the small membership can get together and repay them. The Club is to give a luncheon in Miami in December. William Weston, Jr., is the Master Sergeant-at-arms of the House of Delegates. There were 189 delegates registered to vote. The Trustees can attend but cannot vote. Julian was in the House of Delegates most of the time when the Trustees weren't meeting.

An effort to discontinue the Clinical Session in the fall was discussed, but failed to pass for two reasons. First, physicians in the area where it is held could attend when otherwise they might not. Second, the House of Delegates could not possibly do all the work if it waited a year to meet.

Everyone who knew William Weston, Jr., was proud and happy that he was elected Chairman of the Section on Pediatrics of the A. M. A.

It is now required that the place of the annual convention be specified five years ahead. The following is that list with the clinical sessions as far as has been decided:

ANNUAL	CLINICAL
JUNE	NOV. DEC.
1955 Atlantic City	1954 Miami
1956 Chicago	1955 Boston
1957 New York	1956 Seattle
1958 San Francisco	
1959 Atlantic City	

The American Medical Foundation now has \$1,089,000.00, of which \$500,000.00 was given by the American Medical Association and \$160,000.00 was given by the Illinois Medical Association by assessment of its members. \$5,000,000.00 is expected from industry. One of the highlights of the meeting was the gift of \$100,000.00 to the Foundation by the California Medical Association.

Three men—all of high caliber—were nominated for the president-elect position. Dr. Elmer Hess of Erie, Penn., Dr. Hamilton of Illinois, and Dr. Harvey Stone of Baltimore.

Dr. Hess was elected on the first ballot and was overcome with emotion, as who wouldn't be. Dr. Bailey of Kentucky was elected vice-president by one vote, 92-91.

I came away with greater respect for the Administrative officers especially the secretary, Dr. Lull, and his staff. All the resolutions and reports were typed and in the hands of the delegates within hours of their dictation. How the House of Delegates completes its work is amazing and due to efficient and tireless secretarial work as well as competent speakers. The democratic principle is followed to the letter. Nothing is railroaded. Anyone can discuss any resolution at the proper time. I am proud and feel it a great privilege that I was elected to serve in such a great deliberative body.

George D. Johnson

Polio Vaccine Trial Needs Physicians' Aid As It Moves Into Evaluation Phase

More than 600,000 children have completed three inoculations, in the field test of the trial polio vaccine developed by Dr. Jonas E. Salk of the University of Pittsburgh. The emphasis now shifts to the evaluation study under the direction of Dr. Thomas Francis, Jr., University of Michigan School of Public Health. The validity of the evaluation is dependent upon data gathered on poliomyelitis cases in the test groups, *including those children in the first three grades who did not get vaccine.*

In addition, data on cases among family members of participating children are an integral part of the study. Since the number of poliomyelitis cases among the test groups may not be large, it is essential that all cases are completely reported. Early diagnosis, prompt reporting and follow-up, and the securing of *necessary epidemiological information and laboratory specimens* are important factors in the evaluation.

An outline of procedures and copies of necessary forms have been sent to local and state health authorities. It is important that physicians in areas where vaccinations were not given, cooperate in the study by notifying local or state health officers of cases occurring among children who participated in the trials and then migrated to another area and chil-

dren who go to summer camps. Local health officials also need information on participating children who receive injections of Gamma Globulin.

This phase of the study will depend, to a large degree, on the whole-hearted cooperation of practicing physicians.

Blue Cross and Blue Shield

South Carolina's Blue Cross Plan has been in financial difficulty for months. Should our Blue Cross Plan fail, it would be a catastrophe which would be felt by subscribers, our hospitals, our doctors and our Blue Shield Plan. Actually, since their joint operations are so closely interwoven, failure of Blue Cross would necessitate liquidation of Blue Shield.

It would be true to say that Blue Cross is literally fighting for its life. This fight must be the doctor's fight, and although there must be cooperation of wider scope, without the doctor's help, only failure can come.

The problem will not be solved by increasing membership fees. To do so would so lower the numerical strength of the Plan that the administrative expense would fall too heavily upon those who were able to continue their membership.

The ratio of those receiving hospital care to the total membership, already high, is steadily increasing. This strongly suggests that members of the Plan are entering hospitals for treatment in much greater numbers, proportionately, than are those who do not have Blue Cross. A study of hospital bills for Blue Cross subscribers seems to indicate that the average length of stay, the cost of x-ray and other laboratory examinations and the cost of drugs is greater in all categories than it is for non-members. Blue Cross contracts provide for payments to hospitals on the basis of the average per diem costs of the hospital. Unnecessarily extensive x-ray and laboratory examinations and unnecessarily expensive drugs raise the average per diem costs for Blue Cross subscribers and for all other patients as well.

Doctors have an opportunity to reduce utilization, to reduce the length of stay in hospital, and to reduce the average per diem costs by discouraging unnecessary hospital ad-

mission, by discharging patients as early as safety permits, and by refraining from ordering unnecessary laboratory examinations and unnecessarily expensive drugs.

There is no reason to believe that hospital costs are not too high. True, wages and salaries have gone up, the eight-hour day has superseded the twelve-hour day for all employees, food, drugs and other supplies are higher, and the armamentarium for the treatment of disease has been enlarged tremendously.

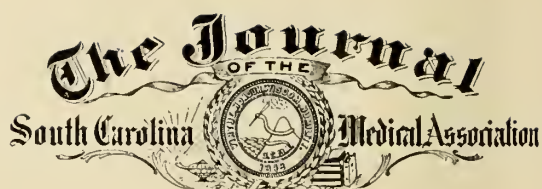
However, along with these necessary increases in costs there are other increases, the necessity for which is questionable. The well public, for themselves and for their sick loved ones, are demanding luxuries in accommodations, food and nursing care. An inspection of any new hospital will show that hospitals are attempting not only to meet that demand, but they have also provided handsome but unnecessarily costly fixtures and equipment which are not related to efficient treatment of the sick.

There is yet another factor. In hospitals as in industry, there seems to be an unwillingness to do a full day's work for a day's pay. Not only is the coffee recess an evidence of this. There is time out to smoke, to retire, to gossip, to daydream. Any observant visitor to the hospital will notice this. The avoidance of continuous application to duties assigned seems to be universal. This attitude necessarily increases the number of employees and thereby increases hospital costs.

Another factor of increased general per diem costs is the unwillingness of governmental agencies to pay the full hospital costs of indigent patients. The paying patients, including Blue Cross subscribers, are then penalized and made to pay the difference between the hospital average costs per day and what is paid for the hospitalization of such indigents.

A final factor in the high cost of hospitalization is the educational program conducted by most large hospitals. It is probably true that paying patients should pay for services received by them from students. However, it is highly questionable whether or not they should pay for those portions of the educational program from which they receive no benefit.

J. Decherd Guess, M. D.



Forty Years Ago

AUGUST 1914

A paper by Dr. Heyward Gibbes was on "Chronic Infections and Their Relation to Internal Disorders"—Dr. Vance Brabham, secretary of the Second District Medical Association, reported on a meeting held at Bamberg. The Board of Medical Examiners reported that 104 of 166 candidates had passed.

Omnia in Risu

I know that the avid readers of *Omnia* in *Risu* are disappointed because of the seemingly irregular appearance of this column in the *Journal*. This is due to a number of reasons and I think that you are entitled to an explanation. I shall list several reasons, in order of importance:

1. There is a certain amount of editorial jealousy among the members of the editorial board and they will delete this wonderful and stimulating column to insert some scientific paper which is probably only of interest to about 90% of the readers.
2. In spite of continued efforts on the editor of this column and his host of supporters, WE have been unable to secure from the State Medical Association Council any money for RESEARCH and I am certain you are all aware of the need for research in any project.
3. Certainly I must not place ALL the blame on (1) the *concrete* or (2) the *abstract* but am willing to assume some of the blame myself. I just haven't written the damn column.

And that brings me to the story of being prepared. It seems that two ministers, one old and the other quite young were traveling through the country one bitter cold night and when a lodging house was found they both ate well of the warm food and immediately prepared for bed. Although the room was quite

cold, the younger minister knelt beside his bed and prayed. He was somewhat astonished to find that the older man had lost no time in getting in bed and seemed comfortably warmed when he, the younger, had finished his prayer. "How is it," he asked, "that you did not pray?" The older man replied, "Son, for such emergencies, I STAY PRAYED UP!" I wish this column could stay written up!

Of course, this column is considered a lighter side of the news and while we want our readers to have some laughter for we believe, "laughter is the shock absorber, easing the blows of life, i. e. He who laughs—lasts." At the same time, we also hope to add from time to time some of the happenings which we consider pertinent, informative and instructive. For instance, when a young actor watching Carmen Miranda execute a fiery South American dance remarked approvingly, "Lots of pepper." Groucho Marx nodded in assent, and added "Nice shaker, too."

It was our editors' privilege and great pleasure to visit one of our neighboring cities last week. This trip to Chesterfield, S. C. was to see the new clinic Hospital that the Perry Brothers had recently completed. Having had a tenure of service in Chesterfield County, I think that this is the nicest thing that has happened to the people of the county in many years—other than my leaving! The modern, state-approved building, designed to care for the patients of the community in a modern manner and staffed by men well trained and devoted to their work is a sight for even my sore eyes. They have already made the impression on the community that most of us spend our entire life trying to make. More power to them.—there will not be any form of socialized medicine as long as we have this type of thinking in medicine. I mentioned this incident since I am reminded of the rooster who, upon seeing a football in the neighbors' barnyard, called all of his hen harem together and said "Now, girls, I'm not complaining but you can see what kind of a job they're doing next door."

Hoping that some of our readers are interested in the Philosophical aspects of Humor, I would like to add a few paragraphs your editor wrote on another occasion.

When I speak of Humor I wish to differentiate at the very beginning from that type mentioned in medical terms. You may recall that one of the important fluids of the eye is the vitreous humor. I have had the unhappy experience of witnessing the loss of vitreous humor during ocular operations and while I must admit it was vitreous, there was absolutely nothing humorous about it or the

situation.

Perhaps another definition of Humor might well serve to get us into the position to understand the meaning of this presentation. A definition is "The mental faculty of discovering, expressing or appreciating ludicrous or absurdly incongruous elements in ideas, situations, happenings or acts. Distinguished from wit as *less* purely intellectual and having more kindly sympathy."

Thackeray says, "I should call humor a mixture of love and wit." No one seems to know exactly why we laugh or why anything that SEEMS funny causes us to make such peculiar noises. And, these noises may range from the gentle and subdued "titter" of the more meek to the more wholesome and hearty laugh of the genuinely amused to the raucous "whanks-whanks" of the entirely unsubdued extrovert but thoroughly convulsed individual.

Why civilization has adopted this noise, initiated by the fluttering up and down of the diaphragm and accompanied by contortion of face and body, still remains a matter of conjecture. However, this urge to laugh appears very early—babies smile, then coo and finally chuckle when pleased—or more often when completely astonished and perhaps frightened by the sight of a loving (1) parent (2) friend or (3) grandparent, in the order mentioned. By the time a child starts to school he will laugh (or cry) at anything he hears or sees—he does not have to have his ribs tickled in order to giggle—as a matter of fact, he or better *she* seems to be a machine which is in a state of perpetual giggle complete with missing front teeth.

Perhaps a short rundown of types of Humor might assist in our thinking. There is THE HUMOR OF THE SITUATION—If a man meets a lady on the street, tips his hat to her, and a pigeon flies out from beneath it, most of the people who see it would laugh—this is the humor of the unexpected. There are others, some a bit more grim but as humorous—The physician who was called time and time again to see the patient who suffered with heart disease—Each time the pain was relieved by a hypodermic injection, and each time the procedure was witnessed by the brother-in-law of the ill man. This he thought was excellent medical therapy. Finally, however, the unfortunate patient suffered the severe and final seizure—Again the physician in an effort to relieve the painful attack, gave the inevitable "shot". As the medication was being administered, the patient expired. The physician glanced questioningly at the ever present relative who returned the glance and came up with this, "Well, Doc, you got him that time".

Another kind of situation humor is called the incongruous, or putting together of two unrelated things. People see dogs every day and think nothing of them but let one walk into a church and a wave of smiles will appear in the now awakened congregation. The dog does not belong there—the situation is incongruous—not to be mistaken for the lower House—Or the Minister being shaved by a colored barber who had inbited a bit freely the evening before. When the barber was admonished by the minister who remarked that his face was bleeding, he replied, “Yas suh, for a fack, drinking do make the skin tender”.

Certain words are funny in their sounds—like bobble and squirt—others amuse us when they are mixed up, such as instead of say, “people thing”, one says, “thinkle peep”. Puns, though supposed to be the lowest form of wit and now called “cornies” by the younger set still furnish us with much of our humor. Shakespeare’s writings are full of puns. Ben Jonson was once asked by a friend to make a pun. Ben replied, “Pun what subject?” The friend laughed and said “Oh the king”. Ben then said, “But the king is not a subject; he is the king.” Perhaps we should relegate the pun to its rightful and shameful place.—Perhaps, too, one should stop this column, but you can have more if you only ask for it.

Blue Cross - Blue Shield

There is misunderstanding and lack of understanding regarding waiting periods before pre-existing conditions are covered by Blue Cross and Blue Shield. Many doctors do not appear to understand the principles involved, and because of their own lack of understanding, are not able to guide and instruct their patients. When an operation is already performed, and particularly if it be an elective one, to have coverage denied on the grounds that the condition for which surgery was done had been pre-existing and the required waiting period not yet terminated arouses the ill will of both the patient and the doctor.

There are only two ways to eliminate the needs for waiting periods. The first is to restrict membership to large groups and require every member of the group to take and to maintain membership in the plan. The second is to require a medical examination and accept first class risks only, or to exclude from coverage treatment of specific impairments found, or to deny coverage of a rather long list of frequently recurring conditions with insidious onset and slowly progressive courses.

Any other method not only invites but encourages people to join the plan with the *anticipation* of having early treatment for an already known or suspected condition.

Much has been said recently about the high utilization in the South Carolina plans. There are several reasons for the fact that more subscribers per 1000 members go to the hospital and receive treatment and stay longer than do uninsured persons per 1000 population. One of the important reasons is that the subscriber often already contemplates hospitalization and treatment for conditions, where the treatment is more or less elective, when he applies for membership in the plans. Instead of the laws of averages, those of selection (adverse selection) often apply to the Blue Cross and Blue Shield groups from year to year, as new members are accepted. It is to guard against excessive utilization due to treatment of conditions already present, to discourage applications from those who instead of representing the *risk* of need of treatment already have the need, that waiting periods have been included in provisions of the contracts.

Both plans have recently changed the wording of the paragraphs in their contracts which have to do with waiting periods for preexisting or already existing conditions at the time the membership becomes effective.

Blue Cross in its current comprehensive agreement states the limitation thus: “Hospital services will not be provided during the first twelve months of membership for any ailment, disease, or condition existing on the effective date of the subscription agreement, or for which medical-surgical treatment or advice was rendered within one year prior to such effective date.” Lack of knowledge of an already existing condition by the subscriber or by the doctor does not alter this waiting period requirement. Neither does the fact that such a condition has gotten worse since the membership became effective. The test is whether or not the condition existed at or prior to the effective date of the Agreement. The decision as to whether a condition was pre-existing is based on the history, the nature of the condition, the statement of the doctor, the operative findings, the report of the pathologist, etc. The ruling of the Medical Director in cases in question is conclusive.

Blue Shield in its latest group-medical-surgical agreement, has discarded the definition and use of the term pre-existing as applied to surgical conditions and has selected a group of chronic conditions which experience has shown to be most frequently subject to abuse and most costly to the plan: “A waiting period of 12 consecutive months from the effective date of the subscription agreement is re-

quired before the following are covered:

"A. Removal or treatment by excision, desiccation, fulguration or cauterization of warts, moles, nevi, skin blemishes, unsightly scars, hemangiomas, lymphangiomas, superficial cysts and lipomas.

"B. Operations for peptic ulcer (except when perforating, acutely obstructive or dangerously and grossly hemorrhaging): gallbladder disease (except acute cholecystitis, empyema or gangrene of the gallbladder, and stone impacted in the common duct).

"C. Hysterectomy for fibroids; operations to relieve retroversion or descensus of the uterus; repair of healed birth injuries (cystocele, rectocele, urethrocele, perineal laceration or relaxation).

"D. Operations to cure or relieve obvious and easily detected congenital defects, deformities or anomalies (except those undertaken within the first two weeks of life)."

The statement requiring a waiting period of twelve months before coverage of already existing medical conditions not specifically mentioned above has been changed to read:

"A waiting period of 12 months from the effective date of the Subscription Agreement is required before treatment of already existing medical conditions is covered. Either recognized symptoms, medical treatment, positive or tentative diagnosis by either subscriber or his physician before the effective date of the Agreement shall be accepted as evidence of such condition."

It should be noted that the subscriber does not have to know that he has been sick. His doctor does not have to know it. No diagnosis needs to have been made. The sole thing necessary is that the condition for which he seeks coverage within the first 12 months of membership was present on the effective date of the contract. Again in questions of doubt, the ruling of the Medical Director is conclusive.

J. Decherd Guess

DR. G. S. T. PEEPLES NEW STATE HEALTH OFFICER

Born April 19, 1903, in Hampton County, South Carolina. Son of Jesse D. and Maude G. Peebles. Grew up and received early education in Bluffton, South Carolina. Received pre-medical education at Clemson College, and graduated in 1926 from the Medical College of the State of South Carolina. His career in public health actually began immediately upon his graduation, at which time he was granted a Rockefeller Scholarship for a post graduate course in preventive medicine. He interned at St. Joseph's Hospital in Savannah, Georgia, and at Roper Hospital in Charleston.



DR. G. S. T. PEEPLES
STATE HEALTH OFFICER
June 23, 1954

CAT.

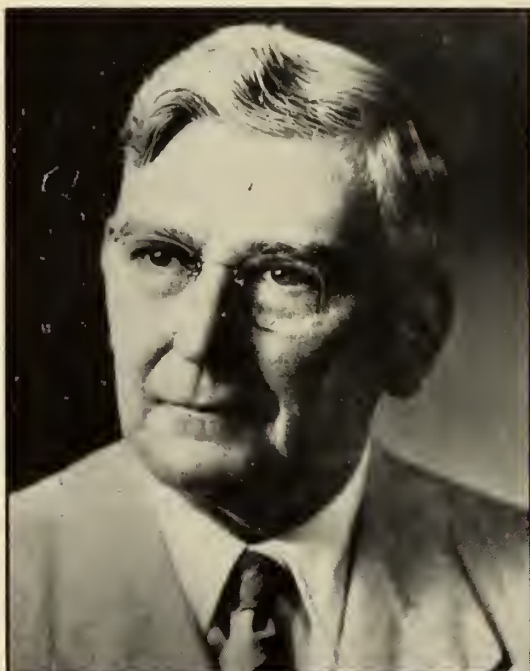
He practiced medicine in Berkeley County at Bonneau and in Charleston, during a part of which time he was assistant in medicine at the Medical College in Charleston. From time to time he has taken short courses in some of the larger clinics in the eastern cities.

Dr. Peebles was county health officer in six counties prior to coming to the central office as Assistant Director of Rural Sanitation and County Health Work (now Local Health Services) in May, 1940. In June, 1942, he became director of the division for Crippled Children, which position he held, along with responsibility for the Cancer Control program during the war, and for establishing and directing the Rheumatic Fever program until October, 1949. He became director of Local Health Services at that time, and in addition, was made Assistant State Health Officer in February, 1952. On June 23, 1954, he was elected State Health Officer by the Executive Committee of the State Board of Health to fill the vacancy created by the death of Dr. Ben F. Wyman on June 18, 1954.

He received a Master of Public Health degree from Harvard University in 1937. During World War II he was commissioned a Surgeon by the U. S. Public Health Service and placed in charge as Medical Director of the Carolina Army Maneuvers. Following this, he was made Assistant State Director of Civilian Defense in Chemical Warfare.

Dr. Peeples has served as President of the South Carolina Public Health Association, first vice president of the Southern Branch of the American Public Health Association, and is a fellow of the American Public Health Association. He is a diplomate of the American Academy of Preventive Medicine and Public Health, a member of the Columbia Medical Society, the South Carolina Medical Association, and the American Medical Association.

Dr. Peeples is married to the former Miss Ruth Colyer of Charleston, and they have one son, Thomas O. Peeples, and two grandchildren, all of Charleston. Dr. and Mrs. Peeples live at the Cornell Arms Apartments in Columbia.



DR. BEN F. WYMAN
STATE HEALTH OFFICER
Deceased, June 18, 1954

DR. BEN F. WYMAN

An Appreciation by the Executive Committee of the State Board of Health.

Knowing that the outstanding accomplishments which marked the professional career of Dr. Ben Wyman have been duly noted in various publications, the Executive Committee of the State Board of Health desires to pay tribute to those particular facets of his personality with which its members are most familiar. To do so by formal resolutions would reflect a relationship between him and the Executive Committee which did not exist.

Dr. Wyman was jealous of the dignity of

public health work. He resisted vehemently any encroachment on the field of public health by unauthorized agencies. He missed no opportunity to claim credit for the Board of Health when such credit was due. No one could have been more zealous for the advancement of the good name of the department which he headed. No one could have defended it more ably than he did when it became the target for unjust and unthinking criticism. It is doubtful that any department of the State has had a more adroit spokesman to represent it before legislative committees and the public at large than did the Board of Health in the person of Ben Wyman. To a great many people, the Board of Health and Dr. Ben Wyman were synonymous terms. This did not imply any derogation of the other personnel of the Board of Health but was a tribute to his aggressive leadership and single-minded devotion to everything concerned with public health in South Carolina.

His intense dedication to the advancement of public health work was made more effective by the efficient manner with which he absorbed the innumerable details of his office. To watch him wade through the minutiae of budgeting, departmental personnel problems and federal agency demands and then come up with a clear, concise resume of the problem was a source of constant astonishment to those on the Executive Committee who shared with him the responsibility of making important decisions. Without his incisive judgement they would have been but poorly prepared to pass on such matters.

The loyalty and devotion which Dr. Wyman commanded from the entire personnel of the Health Department was an all-important factor in maintaining an efficiency of operation through many trying periods—periods when shortage of professional help threw unwonted burdens on those who were already carrying a full load—periods when budgeting problems made it necessary to cut corners at every turn. Such loyalty had its roots in the knowledge of every Health Department official and employee that Ben Wyman would not ask of them what he was unwilling to do himself.

That the Board of Health should continue to function without loss of momentum despite its grievous loss in Dr. Wyman's death is more evidence of the genius for good organization which he possessed. The Executive Committee is in position to appreciate better than most how vital a role Dr. Wyman played in the multitude of activities of the agency which he headed. It feels very keenly the challenge to carry forward the dynamic program which he envisioned and to which he devoted the greater part of his life and energies.

PRESIDENT'S PAGE

During the week ending July 17 Congress voted to recommit the President's bill on reinsurance, H. R. 8356. Whether rightly or not, the general impression is that the A. M. A. was responsible for this. Referring it back to the committee is considered equivalent to killing the measure for this session. One of our members has expressed the hope that since the influence of the A. M. A. is now so great we should be very careful in wielding it; that if used judiciously and not too often and only on the side of or against those proposals which really count, our influence will continue to be weighty.

* * * * *

Subject to approval of Council our next annual meeting will be May 9-12, 1955, with headquarters at the Francis Marion Hotel in Charleston. The Scientific Program Committee is already at work lining up speakers of national prominence and it is hoped that this will be one of the best meetings we have ever had.

* * * * *

It was a pleasure to attend the Second District Medical Society meeting in Columbia on Thursday, July 1, and we regretted that time would not permit the staying over for the dinner and social hour. We have attended several meetings of this society and their programs and fellowship have been tops.

TOM GAINES

NEWS

John W. Rheney, Jr., M. D. has opened an office for the practice of pediatrics at 620 Carolina, N. E. Orangeburg, South Carolina.

Charles H. Zemp, Jr., M. D. has opened an office for the practice of pediatrics at 1105 Lyttleton St., Camden, South Carolina.

Henry Donato, M. D. has opened an office for the practice of surgery at 109-A Ashley Avenue, Charleston, South Carolina.

State Board of Health

The executive Committee met at Myrtle Beach on May 10 and 11. Among various matters considered was that of redistribution of the Crippled Children's Clinic areas, and the question of more equitable division of the orthopedic work among the qualified orthopedic surgeons. It was decided that the directorship of the Crippled Children's division be transferred to Dr. R. W. Ball, and that Dr. Sheriff would continue as director of Maternal and Child Health.

A number of hospitals which do not meet requirements for licensing were considered and due notice was given that unless certain stipulations were carried out the institutions would not be eligible for licensing.

Dr. McDaniel presented a report on the poliomyelitis vaccine program as being carried out in Charleston. It was gratifying to note that 3,555 children had received the first dose of the vaccine. The program was to be completed during the first week of June. No serious reactions have occurred.

Attention was called by the Health Officer to the lack of funds to institute a cancer clinic in Greenwood County.

The Chairman's address was presented to the Committee and approved for presentation to the House of Delegates of the S. C. Medical Association.

Dr. Busbee, after very fine service to the Committee as representative of the S. C. Dental Association, presented his resignation. The Committee accepted it with deep regret and requested that a suitable statement be included in the final printed minutes of the Committee.

The Committee went on record as presenting their thanks to the personnel of the State Board of Health, both Central Office and County. It was felt that valuable contributions were being made to the health of our people and welfare of the State. It was the desire of the Committee to suitably thank each member, the thanks to be included in the final report of the Committee.

The Executive Committee unanimously elected the following officers for the ensuing year: Chairman—W. R. Wallace, M. D.

Vice-Chairman—W. R. Barron, M. D.

Secretary and State Health Officer—Ben F. Wyman, M. D.—This record shows Dr. Wyman elected for four years.

Assistant State Health Officer—G. S. T. Pceples, M. D.

Representatives on Water Pollution Control Authority—V. F. Platt, Ph. G., W. R. Barron, M. D.

GREENVILLE

Frank F. Espey, M. D. has announced the opening of his office for the practice of Neurological Surgery at 123 Mallard Street, Greenville, South Carolina.

Dr. B. E. Kneece, retired colonel, United States

Army, now connected with the state tuberculosis sanatorium at State Park, will conduct the bi-monthly x-ray clinics at the Barnwell county health department.

Coleman Hospital at Travelers Rest will close temporarily for remodeling and installation of new equipment June 30, Dr. T. E. Coleman, director, announced.

GREENWOOD

Dr. Jack C. Seurry has been awarded a year's fellowship in surgery at the Memorial Center for Cancer and its Allied Diseases in New York City.

SUMMERVILLE

Dr. Jack W. Rhodes closed his office for the practice of medicine here in order to have a short vacation before assuming his duties July 1 on the staff of Roper Hospital in Charleston.

Dr. Rhodes will take a year of post-graduate training in pediatrics.

Dr. William Reid Wyly is opening an office here for the practice of medicine. He will be in the building with Dr. Howard Snyder, in the office formerly occupied by Dr. Jack W. Rhodes.

Dr. Wyly moved here this week from St. Stephen.

MARLBORO

Members of the Marlboro County Board of Health have been released by Secretary of State O. Frank Thornton. These members were appointed by Governor James F. Byrnes and will be officially installed and their duties outlined at an early date. With this board functioning the health of the county and the work of the Health department will be extended. Dr. Prentiss M. Kinney has been named chairman with his term of office to run until May 27, 1958. Others on the board and their terms of office are: Dr. Charles M. Graham, Clio, May 27, 1958; Dr. J. Carlisle Moore, McColl, May 27, 1957; Mrs. L. Paul Barnes, Bennettsville, May 27, 1956; Charles R. Hunter, Blenheim, May 27, 1955.

COLUMBIA

Dr. William Weston, Jr. has been elected chairman of the Section on Pediatrics of the AMA.

Dr. Francis H. Gay, orthopedic surgeon and medical consultant to the Crippled Children's Society of South Carolina, heads the list of winners of one of the scholarships awarded jointly by Alpha Chi Omega, national women's fraternity, and the National Society for Crippled Children and Adults.

SUMTER

Dr. Robert B. Bultman opened his office on West Canal Street. Dr. Bultman has completed nine months of post graduate work in obstetrics and gynecology at the graduate school of medicine of the University of Pennsylvania. His practice will be limited to obstetrics and gynecology.

Dr. Bultman began practicing obstetrics and pediatrics in Sumter in 1933. He practiced continuously here from that time until last fall when he entered the University of Pennsylvania graduate school, with the exception of four years spent as a flight surgeon in the United States Navy during World War II.

EASLEY

The State Board of the Southern Baptist Convention has agreed to take over and run the Easley General Hospital as soon as a stage of completion, to be agreed upon by officials concerned, is reached. R. C. McCall of Easley, a member of the board of directors of the

hospital, said another \$250,000 would be needed to complete the hospital under original plans. Approximately that amount already has been spent on the structure.

BARNWELL

Dr. L. M. Mace, a native of Barnwell but now a resident of Rockv Mount, N. C., was a visitor in Barnwell recently. Dr. Mace will practice surgery there after the opening of the Barnwell County Hospital.

STATE PARK

Dr. Rudolph Farmer, assistant superintendent and medical director of the South Carolina Sanatorium will succeed Col. William H. Monerief, present superintendent, on July 1. Col. Monerief, who has been superintendent at the sanatorium for 15 years, has announced his resignation to become effective June 30.

Col. Monerief a native of Greensboro, Ga., assumed the superintendency of the sanatorium May 1, 1939. He received his medical degree from Emory University and upon completing his internship at Grady Hospital he was appointed resident physician at St. Joseph's Infirmary.

Dr. Farmer, who was born in Allendale, came to the South Carolina Sanatorium in July, 1930. He was graduated from Clemson College, received his medical degree from the South Carolina Medical College in Charleston, and interned in Presbyterian Hospital Pittsburgh and General Hospital, Spartanburg. He has done postgraduate work at Trudeau School of Tuberculosis at Saranac Lake, New York, and at Bellevue Hospital, New York.

WEST PELZER

Dr. Dwight Smith, Williamston physician, and his associates, Dr. James Banks and Dr. Neil Boggess, Jr., have opened an office in West Pelzer at 220 Main St.

ANDERSON

Dr. Charles Bailes has returned to Anderson and reopened his medical office at 1214 North Main Street. Dr. Bailes was recalled to active duty with the Navy in 1952 and for the past year and a half has been stationed at the Naval Hospital at Camp Lejeune, N. C. where he was a member of the Department of Internal Medicine.

DR. G. S. T. PEEPLES IS NEW STATE HEALTH OFFICER

The State Board of Health's executive committee named Dr. G. S. T. Peebles as South Carolina's new health officer.

Peebles, assistant health officer and director of local health services for the board, succeeds Dr. Ben F. Wyman. Wyman held the post for 10 years.

A native of Hampton County, Peebles, 51, was a 1926 graduate of the Medical College at Charleston.

He was a county health officer in Horry and Dillon counties in 1926-27, becoming assistant director of local health services in 1935.

Peebles was appointed director of the Division of Crippled Children in 1942 and in 1949 was named local health services director.

A former president of the State Public Health Assn., he is a fellow of the American Public Health Assn.

The executive committee appointed Dr. C. L. Giventon as assistant health officer.

Dr. John P. Allan, of Lancaster, began the practice of medicine in Blackville on May 27.

His offices are located in the offices formerly occupied by Dr. N. B. Edgerton. A native of North Carolina, Dr. Allan received his B. A. degree from the University of North Carolina in 1942. After finishing at the Jefferson Medical College in Philadelphia

in 1947, he interned for one year at James Walker Memorial Hospital at Wilmington, N. C.

He served with the United States Navy from 1948 to 1953. For the past year he has been engaged in the practice of medicine in Lancaster.

Dr. Henry W. Herbert has returned to Florence to resume his regular general practice of medicine at 242 W. Palmetto St.

Dr. Herbert recently returned to Florence after spending four months in Atlanta where he was treated for a recurrent illness.

Dr. Allen Frew today opened her office for the practice of obstetrics and gynecology at 235 South Charlotte Ave., Rock Hill.

Dr. Lawrence N. Ballew of Memphis, is now associated with Dr. H. M. Allison in the practice of obstetrics and gynecology at 907 Pendleton St., Greenville.

Dr. T. G. Stoudenmayer has become associated with Dr. J. Decherd Guess and Dr. R. M. Dacus in the practice of obstetrics and gynecology in Greenville.

GREENWOOD—Dr. Richard E. Hunton has arrived here to begin the practice of medicine and will be associated with the Scurry Clinic.

Dr. Hugh Elmore Smith, has located in Orangeburg for the practice of medicine, and will specialize in gynecology and obstetrics.

Dr. J. W. Schofield will practice internal medicine in Florence in the office of Dr. L. M. Lide at 224 West Cheves St.

Dr. George Edward Wire, Jr., has joined the staff of Johnson Memorial Hospital, Hemingway.

DEATHS

DR. MARION FENDER

Dr. Marion Fender, 63, Ehrhardt physician, died June 17 in the Columbia Hospital after an illness of five weeks.

Dr. Fender, came to Ehrhardt in 1917 and practiced here until his last illness. He also owned and operated a drug store in Ehrhardt and had farming interests.

In 1911 he entered Emory University Medical School, where he received his medical degree in 1915.

For a year Dr. Fender was an interne at Grady Memorial Hospital, Atlanta, then went to New York. He was assistant resident physician in the Manhattan Maternity Hospital. He also was connected with the New York City Health Department and was on the clinical staff at Columbia Hospital. Before establishing practice in Ehrhardt he made a trip to South America as a ship's surgeon.

DR. BENJAMIN F. WYMAN

Dr. Benjamin Francis Wyman, 69, state health officer, died June 18 of a heart ailment at Pawley's Island, where he was vacationing.

Wyman had been executive secretary of the State Board of Health since 1944. Before that, he headed the board's county health work for 18 years.

During that time, county health work in the state developed from a few skeleton organizations to complete departments in each of the 46 counties.

He was past president of the South Carolina Public Health Assn. and chairman of the state polio planning committee, a member of the executive committee of the South Carolina Division of the American Cancer

Society, a director of the South Carolina Tuberculosis Assn., a member of the American Board of Legal Medicine, Inc., and diplomate of the American Board of Preventive Medicine and Public Health.

He also was a member of the State Territorial Health Officers Assn. and for years served as chairman of its maternal and child health committee. He was chairman of the South Carolina Water Pollution Control Authority board and was first vice president of the American College of Preventive Medicine founded earlier this year.

Born at Aiken, he attended Davidson College and the University of South Carolina, where he obtained a law degree. He practiced law for several years in Barnwell before entering the State Medical College from which he received a medical degree in 1915.

Wyman practiced medicine at Aiken, then served two years in World War I, attaining the rank of major. After the war, he returned to practice at Aiken.

His administration of the State Health Department saw the development of a program of heart disease control, the DDT spraying of rural homes and out-buildings for malaria and insect control, diagnosis and treatment clinics for rheumatic fever patients, and the acquisition of Ft. Johnson at Charleston for use as a rheumatic fever hospital. The Ft. Johnson property had to be turned back to the federal government later, however, because no money could be obtained from the General Assembly for its operation.

Other events of his administration: Advent of sodium fluoride therapy to prevent dental cavities; fluoridation of municipal water supplies also progressed; legislation for an effective rabies control program and the start of annual statewide mass inoculation of animals against rabies; establishment of a system of morbidity reporting from practicing veterinarians; creation of the South Carolina Water Pollution Control Authority within the framework of the State Board of Health; hospital and health center construction; inauguration of a merit system for personnel in the health department; expanded public health education program.

He received an honorary doctor of public health degree in 1952 from the State Medical College.

DR. CLARENCE LeROY KIBLER

Dr. Clarence LeRoy Kibler, retired Columbia physician, died June 19, 1954.

He attended Newberry County schools, Newberry College and received his doctor of medicine degree from the University of Maryland.

Taking additional courses at Maryland Medical College and the New York Post-Graduate Hospital, he specialized in the treatment of the eye, ear, nose and throat.

In 1907 Dr. Kibler came to Columbia to begin his practice. He has since become known as one of South Carolina's leading eye, ear, nose and throat specialists.

Dr. Kibler was a member of the Columbia Medical Society, the South Carolina State Medical Association, of which he was a past vice president, the American Medical Association and the Seaboard Air Line Railroad Surgeons Association, of which he was a past president.

ANNOUNCEMENTS

The Tri-State Obstetric Seminar is again to be held September 13, 14, 15, 1954, at the Sheraton Beach Hotel, Daytona Beach Florida.

This Seminar is being sponsored by the Maternal and Child Health Divisions of Florida, Georgia and South Carolina and by the State Medical Association of Florida. The speakers secured to date include the following:

R. Gordon Douglas, M. D., Obstetrician and Gynecologist-in-Chief, New York Hospital.

F. Bayard Carter, M. D., Professor of Obstetrics, Duke University, Durham, North Carolina.

Willis Brown, M. D., Professor of Obstetrics and Gynecology, University of Arkansas, Fayetteville, Arkansas.

James G. Hughes, M. D., Professor of Pediatrics, University of Tennessee.

William Mingert, M. D., Professor of Obstetrics and Gynecology, Southwestern Medical School, University of Texas.

Milton L. McCall, M. D., Professor of Obstetrics and Gynecology, Louisiana State University, New Orleans.

Allen Barnes, M. D., Professor of Obstetrics and Gynecology, Western Reserve University, Cleveland, Ohio.

This Seminar has been approved for credit hours by the Academy of General Practitioners. There will be no tuition fee.

The Nineteenth Annual Congress of the United States and Canadian Sections of the International College of Surgeons will be held in Chicago with headquarters at the Palmer House, September 7 through 10, with advance registration, business meetings, and a meeting of the Woman's Auxiliary on Labor Day, September 6.

SOUTH ATLANTIC ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS

At the regular meeting in January, 1954, the following officers were elected:

President, Dr. Robert G. Nelson, Tampa, Florida

President-Elect, Dr. Waverly R. Pavne, Newport News, Va.

Vice President, Dr. John C. Burwell, Greensboro, N. C.

Secretary, Dr. C. H. Mauzy, Winston-Salem, N. C.

The next annual meeting of the South Atlantic Association of Obstetricians and Gynecologists will be held in Williamsburg, Virginia, February 10, 11th and 12th, 1955.

The South Carolina Pediatric Society will meet on Sept. 13 and 14 in Columbia. The meeting on September 13 will be jointly with the Columbia Medical Society. The program will be as follows:

SEPTEMBER 13—7 P. M.

Dr. Clifford G. Grulee, Jr.—"The Diagnosis and Treatment of Diphtheria—a Continuing Pediatric Problem."

Dr. Harry B. O'Rear—"Treatment of Meningococcal Infections in Children."

SEPTEMBER 14—11 A. M.

Local Speakers

Dr. J. I. Waring

Dr. Robert C. Brownlee, Jr.

Guest Speakers

Dr. Clifford Grulee, Jr., Associate Prof. of Pediatrics, Tulane University—"Infectious Hepatitis in Children."

Dr. Harry B. O'Rear, Prof. of Pediatrics, Medical College of Georgia—"Cat Scratch Disease."

FOURTH ANNUAL SCIENTIFIC MEETING SELF MEMORIAL HOSPITAL

GREENWOOD, SOUTH CAROLINA

SATURDAY, AUGUST 28, 1954

PLACE—HOSPITAL

COMBINED MEDICAL AND DENTAL

10:00 AM—Registration—Hospital Lobby

11:00 AM—"The Diagnosis and Management of Oral Lesions."

Joseph L. Bernier, Colonel, D. C., U. S. Army

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy."

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, *J. Iowa M. Soc.* 42:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, *California Med.* 76:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, *Rev. Gastroenterol.* 20:667 (Sept.) 1953.

4. Goodwin, L. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, *J. Pharm. & Pharmacol.* 4:153 (March) 1952.

Professor Oral Pathology, Georgetown University

11:45 AM—"The Changing Aspect of Thyroid Surgery."

T. Howard Clarke, M. D., Chicago, Illinois

Assistant Professor Surgery, Northwestern University

1:00 PM—Dutch Luncheon in Hospital Cafeteria (wives included)

MEDICAL

2:00 PM—"Diagnosis and Treatment of Intestinal Obstruction."

Samuel J. Fogelson, M. D., Chicago, Illinois

Associate Professor Surgery, Northwestern University

3:00 PM—"Practical Gynecology in Daily Practice"

Mitchell J. Nechtow, M. D., F. A. C. S., Chicago, Illinois

Assistant Professor Obstetrics-Gynecology, Chicago Medical School

4:00 PM—"The Treatment of Pleural and Peritoneal Malignant Effusions."

T. Howard Clarke, M. D.

DENTAL

2:00 PM—"The Management of Lesions of the Oral Cavity."

Joseph L. Bernier, D. D. S.

3:00 PM—Discussion of Dental Problems

GREENWOOD GOLF CLUB

5:30-6:30—Social Hour

6:30 PM—Barbeque

(Informal Dress — Ladies and Gentlemen)

The following moving picture is available on loan—VARICOSE VEINS by William H. Prioleau, M. D. and J. M. Stallworth, M. D., Medical College of South Carolina and the Roper Hospital, Charleston, S. C. The only charge will be for postage and insurance. Request for such loan should be sent to Mr. R. A. Brown Medical Illustrations Department, Medical College of S. C., Charleston, S. C.

This is a 16 mm. film with sound track.

THE AMERICAN CONGRESS OF PHYSICAL MEDICINE AND REHABILITATION

The 32nd annual scientific and clinical session of the American Congress of Physical Medicine and Rehabilitation will be held September 6-11, 1954 inclusive, at the Hotel Statler, Washington, D. C.

Scientific and clinical sessions will be given September 7, 8, 9, 10 and 11. All sessions will be open to members of the medical profession in good standing with the American Medical Association.

In addition to the scientific sessions, annual seminars will be held. These lectures will be open to physicians as well as to therapists, who are registered with the American Registry of Physical Therapists or the American Occupational Therapy Association.

Full information may be obtained by writing to the executive offices, American Congress of Physical Medicine and Rehabilitation, 30 North Michigan Avenue, Chicago 2, Illinois.

Urology Award—The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been graduated not more than ten years, and to men in training to become urologists.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before January 1, 1955.

The Trustees of what is considered America's oldest medical essay competition, the Caleb Fiske Prize of the Rhode Island Medical Society, announce as the subject for this year's dissertation "MODERN DEVELOPMENTS IN ANESTHESIA." The dissertation must be typewritten, double spaced, and should not exceed 10,000 words. A cash prize of \$250 is offered.

For complete information regarding the regulations write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence 3, Rhode Island.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

OFFICERS OF THE WOMAN'S AUXILIARY, S. C. MEDICAL ASSOCIATION

1954-1955

President—Mrs. A. T. Moore, Columbia

President-elect—Mrs. C. R. May, Jr., Bennettsville

First Vice-president—Mrs. E. G. Able, Newberry

Second Vice-president—Mrs. Frank P. Gaston, Rock Hill

Third Vice-president—Mrs. John Cuttino, James Island, Charleston

Fourth Vice-president—Mrs. Rufus Bratton, Rock Hill

Recording Secretary—Mrs. M. J. Boggs, Abbeville

Treasurer—Mrs. B. J. Workman, Woodruff

Historian—Mrs. John Seigling, Charleston

Jane Todd Crawford Memorial Fund—Chairman, Mrs.

Alton Brown, Co-chairman: Mrs. L. P. Thackston, Orangeburg; Treasurer: Mrs. John Brewer, Ker-shaw.

Student Loan Fund—Chairman: Mrs. David F. Adcock, Columbia; Co-chairman: Mrs. W. P. Turner, Greenwood; Treasurer: Mrs. J. L. Sanders, Greenville.

MRS. MOORE ANNOUNCES COMMITTEE CHAIRMEN

Mrs. A. T. Moore, president of the Woman's Auxiliary to the S. C. Medical Association, has announced the following committee chairmen who will work with her in 1954-1955:

Corresponding Secretary—Mrs. W. G. Brunson, Columbia

Bulletin—Mrs. L. C. Davis, Columbia

Convention—Mrs. Richie Baker, Charleston

Doctors Day—Mrs. John G. Ramsbottom, Spartanburg

Finance—Mrs. T. A. Pitts, Columbia

Legislation—Mrs. George Orvin, Charleston

Membership—Mrs. Wallace, Greenville

Publicity—Mrs. R. W. Ball, Columbia, Mrs. N. D. Ellis, Florence

Public Relations—Mrs. J. O. Fulenwider, Pageland

Revisions—Mrs. W. H. Folk, Spartanburg

Parliamentarian—Mrs. H. L. Timmons, Columbia

Printing—

Today's Health—Mrs. T. P. Valley, Pickens

Research and Romance of Medicine—Mrs. W. O. Whetsell, Orangeburg

American Medical Education Foundation—Mrs. Wells
Brabham, Orangeburg
Civil Defense—Mrs. A. E. Cremer, Columbia
Mental Health—Mrs. John Brewer, Kershaw
Nurse Recruitment—Mrs. Alton Brown, Rock Hill
Handbook—Mrs. David A. Wilson, Greenville.

INAUGURAL ADDRESS

By Mrs. A. T. Moore, Auxiliary Convention,
Myrtle Beach, May, 1954

On May 1st I attended a meeting at Wofford College when that institution celebrated its hundredth anniversary. Major General John Montgomery of the Air Corps was the luncheon speaker. He told a story which certainly fits today's occasion . . . "One day while in training to become a pilot, he was flying with his instructor. After gaining quite some altitude and gliding along without any thoughts of fear, his instructor patted him on the shoulder and told him to hold on to the stick. This they had done many times before as the plane was equipped with dual controls. After gaining some more altitude and leveling off he had another pat on the back, and as he turned around he saw his instructor was about to leave the plane by parachute. He heard his instructor say in a fading voice, 'Son, you are on your own!' So it is with me. With this stick (gavel) in my hand and realizing that Ruth has just left the cockpit, I feel as if I am on my first solo flight.

As I begin this service to the Auxiliary and the Medical profession I should like to share with you two mottoes which I have read. The first is "Men are valuable just in proportion as they are able and willing to work in harmony with other men." The other is an old Indian prayer, "Great Spirit, Maker of Men, forbid that I judge any man until I have walked for two moons in his moccasins." To me these are words to live by and I shall remember them as we work together the coming year to further our service to the medical profession and humanity. I appreciate the

honor of serving as your president. I shall strive to merit your confidence, and I shall make every effort to measure up to my responsibility.

A MESSAGE FROM OUR IMMEDIATE PAST PRESIDENT

Together we have progressed toward knowing our communities better by means of a program of health education through community service.

To each officer, committee chairman, county president, and individual member, I offer my sincere appreciation for your support and effort. By your cooperation interest, and skill we know and love each other more and I believe that the public understands and admires the medical profession more.

Successes of the year are your credits; failures are errors of my mind but certainly not of my heart.

The joy of serving as your leader can be surpassed only by a reward of a continuation of your wholesome attitudes and stimulating friendships.

Ruth Alexander Wilson

ESTES SURGICAL SUPPLY COMPANY

Phone Walnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

FELLOWSHIPS FOR BASIC RESEARCH IN ARTHRITIS

The Arthritis and Rheumatism Foundation is offering the following research fellowships in the basic sciences related to arthritis:

1. Predoctoral fellowships ranging from \$1,500 to \$3,000 per annum, depending on the family responsibilities of the fellow, tenable for 1 year with prospect of renewal.
2. Postdoctoral fellowships ranging from \$4,000 to \$6,000 per annum, depending on family responsibilities, tenable for 1 year with prospect of renewal.
3. Senior fellowships for more experienced investigators will carry an award of \$6,000 to \$7,500 per annum and are tenable for 5 years.

The deadline for applications is October 15, 1954. Applications will be reviewed and awards made in January 1955.

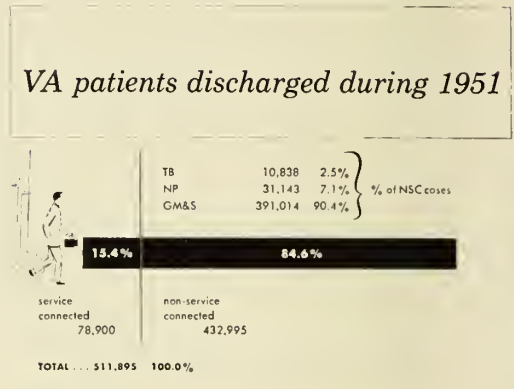
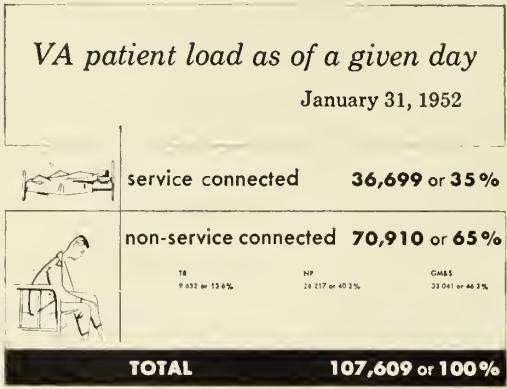
FOR INFORMATION AND APPLICATION FORMS

ADDRESS THE MEDICAL DIRECTOR

THE ARTHRITIS AND RHEUMATISM FOUNDATION

23 WEST 45TH STREET

NEW YORK 36, N. Y.



While the VA lists its patient load on a given day as 35% service-connected, only the long-range view of admissions and discharges over a year's time gives a truly accurate picture of the service-connected load (only 15.4%). This "discrepancy" appears because the VA's listing of 35% on a daily basis is not affected by the yearly turn-over of patients—the ratio of VA patients remaining to those treated and discharged (1 to 5.1). Over a period of a year, 84.6% of VA patients are treated for disabilities incurred after—and having no relationship to—military service.

Of 511,895 patients discharged from VA hospitals in 1951, only 15.4% were treated for illnesses or injuries incurred as a result of military service. Physicians believe it is unsound to continue authorization of "free" lifetime medical care for those who suffer no mishap while in uniform, while other citizens with no military background must pay their own way.

**A LETTER OF APPRECIATION TO
MEMBERS OF THE SOUTH CAROLINA
MEDICAL ASSOCIATION**

Please accept my sincere appreciation and thanks for the recognition given the Winchester Surgical Supply Company and myself at the recent State Medical Association Meeting held at Myrtle Beach for having exhibited for thirty-two consecutive years at your State Meetings.

It has been my privilege and pleasure to have attended these meetings. I regret that I had left the beach prior to the announcement of this honor. Thereby, not having the opportunity to verbally express our gratitude to you, please allow me again to express our sincere thanks for so honoring us.

We look forward with pleasure to being with you in Charleston, S. C. in 1955 for the thirty-third consecutive year.

Sincerely yours,
R. M. Conder

The Journal

of the

South Carolina Medical Association

VOLUME L

September, 1954

NUMBER 9

A Doctor Examines His Profession

PRESIDENTIAL ADDRESS 1954

C. R. F. BAKER, M. D.

Sumter, S. C.

Some years ago the public placed the doctor on a pedestal, and made him a popular hero—the darling of the hour. The public looked up to and loved its doctors—those selfless men who gave their life's blood to serve their fellow man. Old Doctor Smith hadn't saved a thin dime in fifty years of practice, and wasn't it a shame his roof leaked and that poor dear Mrs. Smith was wearing a five year old coat bought in the first place from Sears-Roebuck? It was enough to make your blood boil to see that rich patient of his (a shady character who had made his pile by exploiting great numbers of the poor and ignorant of the town) ride around in a new Cadillac with his wife beside him draped in mink and wearing a three karat diamond ring to boot. Old Doctor was a saint on earth—God bless him—but too kindly to push collecting the pittance he charged, but never got.

Contemporary fiction, radio soap-opera, and the movies spent their all in polishing up the doctor's halo. Doctor heroes were sure-fire, and what doctors they were—only a little taller than the angels in skill, nobility of character, and physical endurance that assured their patients twenty-four hour service complete with toothpaste-ad smiles. They, every last one of them, looked like young Doctor Kildare (one novel had the saccharine title "Young Doctor Galahad") and they all had the medical genius of a Dr. Harvey Cushing or the genial, warm personality of a Buck Pressley. They never, never lost a patient or even bothered to send a bill. They were above and beyond the common rim of men. So removed in spirit from ordinary humanity they

seemed to have no crass details like grocery bills or insurance premiums or keeping three kids in college at the same time to agonize about. Medicine was praised, honored, even revered. "The beloved profession", some woman writer, her pen dipped in treacle, called it. Doctors were classed with ministers and teachers, and spoken of with genuine regret as over-worked, self-effacing, and under-paid! But what spiritual dividends a doctor reaped—what other profession offered such a chance for soul-satisfaction—for following the precepts of the beloved physician, St. Luke, and for dedicating one's earthly existence to the saving of lives and the alleviation of human suffering. The public truly believed that doctors spent their lives in the beautiful shadow of the Hippocratic oath, and took them to its heart with an awed and fanatical devotion. All honor to those wonderful men in white! "Let's encourage our son to study medicine. A doctor has such prestige." All the girls wanted either to marry Clark Gable or a doctor! Doctor worship was at its highest peak, and only a very few rugged individualists had the nerve to mutter, "Dr. X. charged me \$175 for an appendix operation that took him 20 minutes to perform, the highway robber." Such heresy was squelched by the loud defending chorons of grateful patients, "He snatched you from the very jaws of death! Pay and be thankful." Our patients were our biggest press agents and good-will ambassadors, and we were their trusted family friends, their father confessors, and the men like gods who performed miracles and could do no wrong.

But this blissful Utopian love affair between

the American people and the medical profession could not last forever, built, as it were, on the sands of unreality and sentimentality. Doctors were not angels, not infallible, not more patient or unselfish than other men. Patients did die, and some doctors did overcharge, and some surgeons did get themselves a little confused with God, and a few did advertise or take to dope or perform illegal abortions, and a few were incompetent, and a few became rich and indifferently callous to the sufferings of the poor; a few were misfits or dishonest, and a few were lazy and took no pride in their work, seeing nothing in it but a means of livelihood. Doctors were even then, as they are now, ordinary human beings, but enlarged in public opinion to king size. But the medical profession itself has always been a dramatic profession. It literally is, in a manner of speaking, a matter of life and death to each man on earth from the cradle to the grave. Medicine is of absorbing interest to all, and is always, never forget, in the public eye.

Fashions in heroes change, and the pendulum of admiration for the M. D. swung over to censure of him. Almost as much as the South, the medical profession became "target for tonight"—in invective, hostility, and open resentment of its shortcomings, and a whispering campaign opened fire. "*Red Book*" denounced ghost surgery, "*Cosmopolitan*" screamed about needless hysterectomies, Philip Wylie in a particularly uncomplimentary magazine article lumped M. D.s and chiropractors together as one and the same breed. Even the American College of Surgeons let out blast after blast against fee splitting, ghost surgery, and other evils it felt needed to be corrected, each blast sensationally reported in the national news magazines and the great and small newspapers of the land, and what was intended to be a mild in-the-family rebuke was seized upon as an over-all indictment against the good name of the profession as a whole.

To cap the climax, *Collier's* featured on its cover a color photograph of white-gowned surgeons with gleaming scalpels and masked faces, their eyes cruel and hard, sinister and gangster-like. (Any resemblance between

them and the familiar painting of the kindly family doctor watching by a child's sick bed is purely coincidental!) Beneath the *Collier's* Dracula-like picture was the most complimentary title—"Why Some Doctors Ought To Be In Jail." The article itself was not as sensational as the title, but for every two patients who took the time to read the thing through, a hundred saw the damaging cover on the newstands.

In public opinion, it was now the doctor, not the patient who rode in the Cadillac, a Fleetwood, yet, and bought his wife the wild mink and the emerald clip. All doctors were said to live in \$100,000 mansions, dubbed in derision, "Gallstone Gardens", "Cardiac Castle" or "Appendectomy Acres". "My money helped buy Dr. So-and So's new 27 inch television or his Chris-Craft or his duck pond." This cliché was good for a laugh at any time. Doctors were all millionaires, who had to "tote" home their loot in heavy crocus sacks, there to hide it presumably from the income tax collectors! They never took calls at night, and they let charity cases die neglected and unseen. It was the old case of when the patient died, the doctor killed him, and when he lived, God saved him.

The late Dr. Henry Bellaman, talented musician, teacher, literary critic, and author of many novels, unsung and unheralded, never produced a popular success until he hit the jack-pot with "Kings' Row". One of its leading characters was a surgeon, a sadistic butcher, who needlessly amputated both legs of an enemy out of sheer spite.

"Not As A Stranger", the current leader on the best-seller list of novels for spring, 1954, has for its hero, a heel who married the Swedish operating room nurse he scorned and despised to get her money to put himself through medical school. Another doctor character in the same novel is portrayed as thinking up the humane trick of wheeling aged charity patients to an unheated X-ray room at night in the fond hope that pneumonia would kill them off and make room for paying patients.

Thus, in fact and in fiction, the sights are trained on the shortcomings of the medical profession, and it would be wishful thinking

to say that public confidence in M.D.s has not been badly shaken. It is the doctors themselves, the patients charge, who are bringing on socialized medicine with their high prices and high and mighty ways. We have been soundly scolded for our ethics, for making the A.M.A. a sort of lodge or secret society, for professional jealousy, for conceit, sheer cussedness and pomposity, for exorbitant hospital costs, for being cold, inaccessible, unsympathetic men of science, for burying our mistakes, and even, God help us, for referring to patients as laymen!

How solidly based the indictment is or is not, is the \$64 question I shall discuss with you, my colleagues and friends, today, closely bound as we are by the ties of a common devotion to the profession that we chose for our life's work. All of us here have felt the stress and strain of our responsibility as custodians of human life, sweated out tough decisions, kept a death watch over a close friend we weren't due to lose, and sent home cured the stranger doomed to die. We know the meaning of gruelling physical work, as well as any day labourer, and we have seen it take its toll too terribly many heart-breaking time of this colleague and that. "Poor Barry! A coronary, you say? How old was he? Forty-five! Feeling a little under the weather myself—I'll have to try to take things easier—well not now, but maybe next year."

In Stephen Paget's "Confessio Medici", he says of young aspiring fledgling doctors, "Calls, they imagine, should master men, beating down on them; surely a diploma, obtained by hard examinations and hard cash, cannot be a summons from Heaven. But it may be. For if a doctor's life may not be a divine vocation, then no life is a vocation, and nothing is divine." We may not think in such high-flown terms or feel our lives as doctors have been even partly divine, but each of us at one time *chose* medicine. We were not pushed into it, but we chose it as our natural bent and spent long, young, impatient years in training, and fought our way into practice.

I, myself, grew up in the home of a doctor father, and early felt the fascination of his calling. It honestly never occurred to me to choose another profession, but I was not

hounded or driven to it by parental urging. I simply would not have known what to do with my life unless I had studied medicine. As much as I hate to admit it, I entered the University of Virginia Medical School in 1922, so for thirty-two years I have been subjected to medicine in all its many facets, and I have never had reason to regret my choice—not for long at a time anyway. Discouragement at times is the doctor's lot. During these thirty years, there have been many, many revolutionary advances in medicine, and I want to list briefly some of the ones that impressed me most, the list of necessity incomplete.

By the way, I went down to Atlanta for a meeting of the American College of Surgeons last year, and while there we had an amusing presiding officer at one session. Of course, everyone has heard the old saw about a specialist being one who knows more and more about less and less, but this gentleman had a new one. He said that a specialist was an S. O. B. with some slides! I am positive that I cannot qualify—as a specialist, but I do have some slides!

SLIDES

OUTSTANDING MEDICAL ADVANCES

- 1922—Insulin extracted by Banting and Best.
- 1923—Large scale immunization against diphtheria. Malarial treatment of paresis.
- 1924—Discovery of cause of scarlet fever by George and Gladys Dick.
- 1926—Maude Slye proved that certain types of cancer are inherited.
- 1927—Liver therapy for pernicious anemia discovered by Minot and Murphy. Later found to be Vitamin B₁₂.
- 1928—A. W. Adson of Mayo Clinic, operated on the sympathetics for Raynaud's disease.
- 1929—Isolation of the female sex-hormone.
- 1930—Landsteiner received the 1930 Nobel prize for the discovery that human blood falls into 4 great groups.
- 1931—Flcas found to be the carriers of typhus fever.
- 1933—First complete lobectomy reported by Evarts Graham.
- 1934—Sympathectomy for hypertension. Synthetic production of male and

female sex hormones.

Prontosil or sulfanilamide—its use reported from Johns Hopkins.

1938—Use of nicotinic acid for pellagra.

1939—Shock therapy for psychoses.

Operation for patent ductus arteriosus.

1940—Successful vein grafting.

1941—Polio—carried by flies and may enter the body through the alimentary tract or through the lungs.

Gramicidin first used on humans and found effective.

Compulsory vaccination of troops against tetanus.

Troops vaccinated against yellow fever.

1942—Institution of Red Cross blood banks.

1943—Penicillin therapy introduced. Discovered in 1928.

Rh factor discovered.

1944—Gamma globulin used for measles and albumin for shock.

1945—Streptomycin introduced.

Successful operation for blue babies.

Thiouracil used for toxic goitres.

1947—Valvulotomy used for heart lesions.

1949—Cortisone and ACTH introduced.

1951—Polio virus first grown on tissue cultures.

1954—Possible effective vaccine for polio.

Now let us summarize. Practically all of the acute infectious diseases that were at times epidemic in the past have been conquered by vaccination. It has been many years ago since smallpox was licked, and in the late twenties diphtheria was almost obliterated. Now we are beginning a mass vaccination that we are optimistic will eliminate the last and most terrible of the known epidemic diseases—polio.

Furthermore, during this same period we have discovered drugs that will cure the infectious diseases that could not be eradicated by vaccination. First came the sulfa drugs, then penicillin and other antibiotics. At present, the tubercle bacillus is practically the only culprit left at large.

During these years, too, came into full flower the vitamin! Sometimes I think we are living in the Vitamin Age as well as the Aspirin Age and the Atomic Age! But levity aside, Minot and Murphy found how to cure

pernicious anemia, a heretofore completely incurable disease, with liver. Later, B₁₂ was found to be the active principle in the liver. We have niacin for pellagra, and vitamin K has proved a God-send to control bleeding in surgical cases.

The intricate workings of the endocrine glands have been examined and explored. Their functions are better understood and many of their active principles have been isolated and prepared synthetically. As mentioned above, Banting and Best in 1922, isolated insulin, a milestone of triumph in medical research, and recently cortisone and ACTH have become a latter-day miracle drug in the treatment of arthritis and other pain-wracking diseases.

In the field of surgery, the last two systems of the body have fallen prey to the scalpel. Up to the time of Evarts Graham, the lungs were considered inviolate. Since then, the heart has been attacked. The valves are cut, the large arteries and veins are rerouted, and both veins and arteries can be resected, or sections excised and grafted.

Perhaps, however, the greatest advances in surgery have come from a better understanding of fluid and electrolyte balance in the body and from the amazing improvements in anesthesia. Without the excellent anesthesia of today and without the availability of massive amounts of blood for transfusion, the spectacular operations mentioned, and many others of lesser degree could not be performed. Operations on the aged, once considered daring or hopeless, are now commonplace and are on the main as successful as in other age brackets, primarily because of intimate knowledge about these subjects.

What do these facts mean to us and to the public welfare? Along with great improvement in infant mortality, it means that normal life expectancy has been increased from 58½ to 70 years.

At this point, it might be of some interest to you to hear that in my father's presidential address to the S. C. Medical Association in 1909 he predicted, "If the five diseases, tuberculosis, entero-colitis, typhoid fever, pneumonia and diphtheria were prevented, the average life span would be increased 8 to 15

years." Two of these diseases can now be prevented, two can be successfully treated, and tuberculosis is the only remaining scourge.

In conclusion, consider for a few minutes one or two complaints against the medical profession. The public says we are a closed corporation, that there are not enough doctors to go around, and that we are trying to limit the number of students in our colleges. In 1922, we had one doctor for every 729 people in this country; in 1950 we had one for every 730 people, one more person per doctor. We have better doctors now for there are no longer any Grade B medical schools or any diploma mills.

During the past eleven years the enrollment in medical schools has increased 27%. In 1952, 6080 physicians were graduated, and the 1953 classes were even larger.

The A.M.A. has donated one and a half million dollars from its own treasury to support medical schools. Does that sound like the A.M.A. is limiting the number of doctors?

As to the cost of medical care, the average person today pays only 4% of his income for medical care, the same as his parents before him. Of this 4% the doctor gets only 28%, and the rest goes for medicines, hospitalization, etc. Twenty years ago the doctor got 32%, more than at the present time.

Hospital charges have gone up faster than any other medical expense, but hospitalization is so shortened that often the hospital bill is lower than in the good old days. This quick hospital turnover is of course due to more effective drugs, modern equipment, improved

surgical safeguards, and better over-all care.

Statistics alone, however, cannot convince our patients our prices are not too high—we are now suspect! But maybe someday you will have an experience to warm the cockles of your heart. Anyhow, a general practitioner friend of mine did. He was called recently to see a prominent and well-to-do plumber, found that said plumber had a mild attack of tonsillitis, and injected 300,000 units of penicillin. The patient asked cagily what the charges would be, and my friend told him \$6—\$3 for the house call and \$3 for the penicillin. The patient frowned a minute, then smiled in friendly fashion and said, "Well, I guess that's about right, doc. When my assistant plumbers make a call, they charge \$3 a house visit, and they charge extra for the materials."

With this encouraging story, I shall rest my defense of medicine, and end on a note of hope for its future.

As Dr. Harvey Cushing said in 1926, in his book of medical essays, "Consecratio Medici", "A spirit of devotion is the mainspring of our profession." Those are splendid words, and I say to you that in 1954, we still have that spirit—that and a pride in our profession, and in the good it has always accomplished and will continue to accomplish in spite of the avalanche of criticism hurled against us since World War II. In public opinion, our halo may have dimmed a little, but, human shortcomings notwithstanding, medicine is still a going concern.

Common Proctologic Problems^{*}

LOUIS A. BUIE, M. D.
Section of Proctology,
Mayo Clinic and Mayo Foundation,[†]
Rochester, Minnesota

Mr. President, Members of the South Carolina Medical Association, Ladies and Gentlemen:

This morning you heard a young physician read an essay which was quite enlightening, and I am sure that you were inspired by it. It is very comforting to know that young physicians of today understand the problems which face the medical profession. Dr. Baker's presentation was down-to-earth and factual. The facts which he enunciated confirm the philosophy that the physician can no longer limit his endeavors to the care of the infirm. He now finds it necessary to do things which were not regarded very highly some years ago. He used to look with disdain upon activities which dealt with political problems. He felt that it was beneath the dignity of members of the medical profession to engage in any activity of a political nature. I agree with *everything* that Dr. Baker said regarding the exalted position which was once occupied by the American physician as compared to that which he now reluctantly has to accept because of unfavorable conditions which have existed in this country during the last 10 or 15 years. I hope you will accept his suggestions, because unless you and other men like you assume your responsibility in these matters, the outlook for the profession of medicine is indeed unattractive. This very sad state of affairs is owing to situations which have been largely beyond the control of physicians, but I believe that the American medical profession can solve the problems which face it, through men like Julian Price and "Buck" Pressly. They will agree that Dr. Baker has presented to you problems which you should accept as your responsibility.

^{*}Excerpts from an address read at the meeting of the South Carolina Medical Association, Myrtle Beach, South Carolina, May 11 to 13, 1954.

[†]The Mayo Foundation is a part of the Graduate School of the University of Minnesota.

And now to my assigned subject, "Common Proctologic Problems."

People are beginning to realize that it is not necessary to answer advertisements in newspapers and magazines in order to obtain relief for proctologic conditions. Quack institutions do not flourish as they did at the turn of the century. They have lost control of a large segment of proctologic practice because members of the medical profession have become awakened to their responsibility in managing conditions which afflict the anus and rectum.

When a patient consults a physician and admits that he has rectal trouble, probably it is quite a serious matter to him. Usually such individuals are reluctant to reveal their rectal problems. They have heard about the clamp and cautery, and flee from such methods to advertisements which describe "painless pile dissolvment methods" and "cures without the knife." It is only natural that they would want to seek some other type of assistance than that which is afforded by burning operations and other unsightly procedures which even now prevail in some hospitals.

Your first duty when a patient consults you is to find out what is wrong. You must examine him carefully and in order to accomplish this it is necessary for you to know how to take care of your patient while performing the examination.

Usually the patient consults you because he has pain. If he merely should be passing a little blood occasionally, I doubt that he would pay much attention to it. He might go to a drug store for an ointment or a suppository and that might end it unless the bleeding persists. However, if he has pain, he will consult you and you must show him unusual consideration if you hope to perform an examination satisfactorily. Too much emphasis cannot be placed on the importance of this examination. Approximately a fifth of the patients in

whom I have discovered cancer have been treated for something else during the period of their symptoms and the cancer has remained undiscovered. It is a good rule to *assume that a patient has a cancer until you prove that he does not have one!* If he is willing to consult you, he is entitled to a thorough examination and you must accept that responsibility. If you do not intend to accept it, you should send your patient to someone else. Any surgeon, internist, gastroenterologist or general practitioner should be able to examine a patient's rectum.

Sixty per cent of the operations performed in this country today are done by general practitioners, and many such operations are done well. Many of those practitioners are not diplomates of the American Board of Surgery or members of an exclusive surgical organization. Nevertheless they occupy a high position in the communities which they serve, and they occupy that position because of their capabilities. Also, they know their limitations!

Proctoscopy

Now let us consider the subject of proctoscopy. Remember that your patient probably has summoned all his courage to come to see you. Are you going to increase his burden by telling him to take a dose of castor oil and come back tomorrow morning after he has taken several enemas? Are you going to tell him not to eat supper or breakfast? After such a routine he is a pitiful spectacle. When he reaches your office you place him in the knee-chest position in which he has to maintain himself while you attempt to examine him. There is a table which inverts the patient and relieves him of much effort. If you do not have such a table, you can arrange a patient over the side of a bed, and by placing his elbows on a pillow on the floor and allowing his legs to cross the bed, you can accomplish much the same result as that provided by the inverting table. In the inverted position it is possible for the abdomen to swing free and when the proctoscope is inserted into the rectum and the obturator is withdrawn, air rushes in, the intestines fall out of the pelvis and the examination can be performed satisfactorily.

I wish to emphasize here that proctoscopy should be preceded by a digital examination.

If you suspect that there is a lesion high in the rectum or in the lower portion of the sigmoid, you should place the patient in the lithotomy position and do a bimanual examination with the index finger of one hand in the rectum and the other hand on the lower portion of the abdomen. The main objective of the digital examination preparatory to proctoscopy is to determine whether there is a painful condition or an obstructive lesion which will interfere with the proctoscopic examination. The index finger should be inserted carefully and slowly and if this can be accomplished there is little doubt that the proctoscope can be inserted, since most proctoscopes are made so that their circumference is about the same as that of the average index finger.

General anesthesia should not be employed—perforations have occurred during proctoscopy when general anesthesia has been used. Your patient's co-operation is necessary and of course it is impossible unless he can reveal his discomforts to you. You should speak kindly to him and encourage him to believe in you. Sometimes, in spite of your best effort, he will not accept a complete examination. Sometimes a short mesosigmoid or a growth may interfere with the progress of the proctoscope. After the instrument has been inserted through the anus, the obturator is removed and the remainder of the examination is conducted under direct observation. If the examiner himself has had a proctoscopic examination, he knows how it feels when the proctoscope enters the rectum and he can tell his patient what to expect. It is important to anticipate the patient's discomforts and explain them to him before he experiences them. Attempts to provide a formula for proctoscopy are futile.

Polypoid Disease

Now I should like to discuss with you the subject of polypoid disease, and in the beginning I want to issue a warning. If you find a polyp that is pedunculated and the bowel wall is not involved, you may fulgurate it. But if there is a broad base, the problem is different. You may fulgurate a polyp that has a pedicle and destroy it completely without destroying its point of attachment. But if it is attached to the bowel wall by a broad base, you cannot

destroy it completely by burning it off the bowel wall; you must also destroy that part of the bowel wall to which it is attached. There may be no microscopic evidence of infiltration but that should not delude you.

If the lesion is attached to the posterior rectal wall and occupies a position below the peritoneal reflection, you can destroy the polyp and also that portion of the bowel wall to which the polyp is attached. You can even destroy some of the tissues in the retrorectal space along with the glands adjacent to the growth. On the other hand, if the polyp is in the sigmoid in the mobile portion of the bowel which lies within the peritoneal cavity, fulguration could be complete only if the burning procedure were carried through the substance of the bowel wall and into the abdominal cavity. Usually polyps are adenomas and, I believe, all of them will become malignant if the host lives long enough; hence it is necessary to treat them radically. When thorough fulguration is impossible, a surgical operation should be employed in order to assure complete removal of the growth.

Frequently you will find a small polyp adjacent to a cancer. Whenever I discover a polyp, I redouble my efforts to determine if a cancer lurks nearby. In a series of 200 consecutive cases in which my colleagues and I discovered a polyp, we advised that it be destroyed; 4 patients did not follow our advice. Within a period of 4 years, all 4 patients returned and in each we found cancer at the site of the polyp.

Anal Abscess and Fistula

During the sixth or seventh week of embryologic life the hindgut projects downward, the proctodeum dimples in and they unite to form the anal plate. With the dissolution of the anal plate, the pectinate line is formed. Thus the junction of the anus and rectum is established. Above and below this line there is a definite differentiation between the vascular, the lymphatic and the nerve structures. The lymph drainage above this line passes into the sacral and the hypogastric lymph nodes and below that line it goes into the inguinal nodes. Above the line the venous drainage is into the caval circulation and below it the veins empty into the portal circula-

tion. Above the line the nerve supply is sympathetic and below it the nerve supply is spinal.

The anal canal is lined by a transitional type of epithelium. At its cephalad border we find the papillae of Morgagni which overlap the mucous membrane to form the anal crypts. It is through the anal crypts (the crypts of Morgagni) that infection gains admittance and provides the undermining process which is responsible for fissures, fistulas, hemorrhoids and other conditions of an inflammatory nature. An abscess is the first physical evidence of the disease which eventuates in a fistula in ano. Prior to the development of the abscess, the patient is scarcely ever aware of any disorder and at that time there is rarely an opportunity to provide treatment. The proper method to adopt when dealing with the abscess is not always easy to determine but it is important. Often it is difficult to determine the opportune moment to incise the abscess. In general it is best to allow it to become fluctuant and to approach, as nearly as possible, the point of rupture. By waiting, the wall of the abscess may become well outlined and when the abscess breaks through the surface of the skin or is incised through a thin partition, the wall of the abscess becomes continuous with the margin of the skin. If the abscess must be incised through several centimeters of normal tissue, the cut surfaces become exposed to the purulent discharges and the patient may become very sick. Abscesses occur in many different situations as indicated by such terms as "ischioanal," "ischiorectal," "supralelevator," "pararectal" and "pelvirectal." The type of surgical treatment is determined by such factors.

The abscess should be incised at its most fluctuant point by a cruciform incision. In this manner four points of tissue can be excised and a large opening remains. Unless the abscess is unusually large, the external opening provided by the incision should be as large as the widest dimension of the abscess. Often a finger is inserted into the cavity of the abscess. Such an exploration is not only unnecessary but dangerous, and if the pyogenic wall of the abscess is broken down by this

maneuver, serious systemic complications may arise. Thus, simple incision and drainage and provision of an adequate outlet are all that are required. Then the acute condition is allowed to subside, during which chemotherapeutic agents may be employed (the use of these agents in an attempt to abort the abscess usually is futile). It is then necessary to allow sufficient time to elapse for the abscess wall to contract into a fistulous tube prior to the curative operation of fistulectomy.

Physicians should impress upon patients the fact that incision and drainage of the abscess is not a curative procedure and that a second operation will be required. Unless this is done, patients may become discontented when they discover that a draining sinus persists and they may even seek assistance from another physician.

The difficulties which arise in the management of fistula in ano are largely owing to a faulty conception of its origin. Also, there is much confusion regarding the meaning of the terms which are used to designate it. For example, the terms "anal fistula" and "rectal fistula" are often used interchangeably but the conditions are not the same. Again, the term "internal opening" is employed almost universally to designate the portal of entry of the infection which caused the condition and is considered to be the primary source of the disease. The error of such usage can be understood when one realizes that an internal opening may exist high in the rectum where the abscess has ruptured into the bowel, instead of externally on the buttocks, as is usually the case. Such an internal opening has nothing to do with the origin of the fistula. Other diffi-

culties associated with the management of this disease may be attributed to the fear of cutting the anal sphincters, the habit of packing the wounds and leaving the packing in too long, and improper or inadequate post-operative care.

The operation of fistulectomy consists in converting all of the fistulous "tunnels" into open "ditches." This always involves cutting of a portion or all of the external sphincter, and sometimes the internal sphincter (so-called) must be incised. The operation is completed by cutting away overhanging edges and excision of those portions of the fistulous tract which are nearest to the point of origin. Sometimes lateral tracts extend superficially and can be treated as a sort of marsupialization procedure.

The postoperative management is as important as any phase of the care of the condition. Wounds should not be packed excessively and the "packing" should not be allowed to remain in the wound cavity longer than 72 hours. When dressings are removed that early, it will be observed that the walls of the wound will bleed, indicating that no fibrous membrane of scar has lined the wound cavity. Thus, the walls of the wound will grow together if it is dressed daily and precautions are exercised in order to avoid packing the walls of the wound apart. Finally, with the adherence of the opposing walls of the wound, a block of scar tissue will be interposed between the cut ends of the anal sphincter, to which it will adhere, and upon action of the muscles, the outlet of the rectum will be closed as efficiently as if the muscle fibers were continuous.

The Clinical Significance of Peptic Ulcer From the Surgical Viewpoint

HENRY W. MAYO, JR., M. D.

The term "peptic ulcer" has been used traditionally to include not only the ubiquitous duodenal ulcer, and the somewhat less common gastric ulcer, but also the jejunal or marginal ulcer occurring after certain surgical operations, the uncommon peptic ulcer of the lower end of the esophagus, and the ulcer occurring in relation to a Meckel's diverticulum which contains secreting gastric mucosa. The last two forms are so infrequent in average clinical experience that they do not merit discussion here; the jejunal ulcer, so common in the days when gastroenterostomy was accepted as a definitive procedure for duodenal ulcer, should become more of a rarity as the criteria for an acceptable operation for duodenal ulcer are more universally recognized.

There is a good deal of evidence to support the suggestion that gastric and duodenal ulcer may be different diseases, although they are traditionally considered under the common term of "peptic ulcer", presupposing peptic digestion of gastric and intestinal mucosa as a causative factor, and although the histologic characteristics of lesions in these two locations are the same. A century ago, gastric ulcers were seen more commonly at autopsy than duodenal ulcers, but in the last three or four decades, the duodenal ulcer has become many times more common than its gastric counterpart. In addition, although the preponderance of duodenal ulcers in the male sex at the present time is well known, a century ago women were afflicted more frequently with this disease. From these statements, one may infer that duodenal ulcer is a disease which has increased commensurate with the greater complexity of modern civilization. Gastric ulcer is diagnosed with frequency in phlegmatic, lethargic individuals, but the duodenal ulcer, as a rule, is inseparably associated with the hyperkinetic, hard-driving "worry wart" type

of individual, thus indicating a possible psychosomatic basis for the disease. The presence of gastric ulcer is usually associated with normal or low acid values in the gastric juice after histamine stimulation, but the presence of an active duodenal ulcer is nearly always associated with high acid values. The measurement of 12 hour nocturnal gastric secretion, which might be considered a measurement of the cephalic or inter-digestive phase of gastric secretion mediated through the vagus nerves, inevitably results in recording increased volume as well as increased acidity for those patients with duodenal ulcer, but this is not commonly true in the gastric ulcer patients. Finally, although the development of carcinoma in close relationship to a duodenal ulcer is practically unknown, carcinoma is a common complicating factor in the management of patients with gastric ulcer. With these ideas in mind, it becomes obvious, despite the common generic term "peptic ulcer", that one must consider the gastric and duodenal lesions separately from a clinical standpoint. In general, the duodenal ulcer is considered primarily as a medical problem, although many cases may require surgery ultimately, and conversely, gastric ulcer must be considered primarily as a surgical problem, although some cases may be satisfactorily managed by conservative means.

The definite cause of duodenal and gastric ulcer is unknown, but certain etiologic factors have become apparent. Perhaps the most important of these is the demonstrated ability of a mixture of hydrochloric acid and pepsin to digest gastric or intestinal mucosa, resistance to this digestion being diminished in the more caudal segments of the gastro-intestinal tract. The trauma of the passage of food materials along the lesser curvature of the stomach, and the "jet effect" of chyme squirted through the pylorus is also important, and these two factors have been taken into consideration in the conventional medical anti-ulcer therapy, as well

From The Department of Surgery, Medical College of South Carolina, Charleston, South Carolina.

as in surgical treatment of the disease. The previously mentioned psychosomatic factor has been seized upon by the vagotomists as well as by the proponents of anti-cholinergic drugs. Other factors, the importance of which is less obvious, such as vascular spasm or vascular stasis, allergies, nutritional deficiencies, and pre-existing inflammation, have received less attention from therapists, both medical and surgical.

Since there must be a definite difference in the clinical attitude toward the patient with gastric ulcer and the patient with duodenal ulcer, it is necessary that any patient with persistent dyspeptic symptoms have a proper radiologic study with fluoroscopy performed by a competent radiologist, not only to determine the location of the ulcer, but to determine its size, the degree of deformity associated with it; the presence or absence of partial obstruction, and to evaluate the possibility of the presence of associated carcinoma.

1. *UNCOMPLICATED DUODENAL ULCER.* There is general agreement that the uncomplicated duodenal ulcer is primarily a medical problem. Some of these cases can be cured, and many can be controlled, in the sense that diabetes mellitus is controlled by insulin therapy, with proper diet and medications. *In evaluating the results of such therapy, it is necessary to recall that duodenal ulcer is a disease of remissions and exacerbations.* Characteristically, there will be flare-ups in the spring and in the fall, with healing of the ulcer in the summer and winter, and it is not infrequent to observe temporary healing of an ulcer as a result of a restful vacation without medication. Enthusiastic internists, research men backed by grants from pharmaceutical houses, and particularly the drug house detail men, tend to tout the current method of treatment in vogue which they wish to emphasize, be it antispasmodic, a new form of alkali, an anti-cholinergic drug, or simply a modified diet, by showing X-Rays and case reports in the name of clinical research indicating that within two to three weeks after the institution of therapy the ulcer was healed and the patient was free of pain. The general practitioner is in a far better position to judge the efficacy of

various forms of treatment for ulcer, since he has the opportunity to see the patient as soon as recurrent symptoms develop, whereas there are many defenses between the patient and the specialist. Certainly no cures of peptic ulcer can be claimed until the patient has been followed for a year or more. In many cases, once an ulcer has reached a chronic stage with the deposition of much scar tissue in its base, healing is by covering of this avascular scar tissue with thin "scar epithelium", which, much like the scar epithelium over extensively burned areas in the skin, tends to break down as a result of the slightest trauma, with the development of recurrent ulceration. In many cases, it will be the patient, and not the ulcer, who is refractory to treatment, and yet some of the failures to adhere to diet and medications will be on sound economic grounds. It seems unjust to deny these individuals the benefit of a surgical operation which should be curative in about 90% of cases. The same may be said for the patient who has repeated recurrences of uncomplicated duodenal ulcer, despite adequate therapy. Again, although several trials of medical therapy are justified, it seems equally unjust to allow such a patient to suffer indefinitely intermittent episodes of unbearable ulcer pain which is incapacitating, without offering him surgery as a possible curative procedure.

2. *PERFORATION:* Acute perforation of a peptic ulcer is a definite indication for emergency operation, which will usually involve simple closure of the perforation with a tab of omentum. If a gastric lesion is perforated, and simple closure is carried out, biopsy of the lesion should be taken in an effort to determine if associated carcinoma is present. At the Roper Hospital, it has been our practice to perform emergency gastric resection for those patients with perforated gastric lesions with minimal peritoneal contamination, who arrive in the hospital a short time after the perforation has occurred, and in whom the general physical condition does not contraindicate a procedure of such magnitude. In such manner, primary resection not only rids the patient of the ulcer diathesis, but eliminates the immediate threat to his life as well. In other clinics, there is a growing ten-

dency to perform primary gastric resection for cases of perforated duodenal ulcer seen shortly after the onset of perforation. We have adopted this procedure with some hesitancy, confining it for the present to those patients who have a long history of ulcer difficulties, previous perforation or hemorrhage, or a large chronic ulcer. Primary gastric resection in the face of perforation is a rational procedure, since about two-thirds of those patients who survive simple closure of a perforated ulcer will have later difficulty requiring strenuous medical or surgical therapy. Except in those cases arriving in the hospital in a moribund condition, and those in which there is a good deal of doubt about the diagnosis, conservative treatment with suction and antibiotics seems unwise, since the material contaminating the peritoneum is not removed, and since the size of the perforation and the location of the ulcer are not determined.

3. **HEMORRHAGE.** Between 80% and 90% of cases of bleeding from gastric or duodenal ulcers will be controlled with suitable hospital medical therapy, including the administration of an adequate amount of blood. A few individuals, particularly those in the older age groups, with large chronic ulcers situated on the lesser curvature of the stomach, or on the posterior wall of the duodenum, will develop hemorrhage resulting from erosion of large vessels which will be uncontrollable by such conservative measures, and which will require emergency gastric resection to avoid death from hemorrhage. Those cases in which the bleeding is not promptly controlled by diet, anti-acids, anti-spasmodics, and blood transfusions, and those in which the bleeding recurs despite such medical measures are definite candidates for immediate gastric resection, and others must be chosen on the basis of the combined clinical judgement of the internist and surgeon while the patient is under very close observation in the hospital. An older patient who recovers from a single episode of severe hemorrhage should be a candidate for elective gastric resection, and a younger patient who has had several similar episodes should be given the benefit of such surgery.

4. **OBSTRUCTION:** Cicatricial contraction

of the pylorus resulting from recrudescences of duodenal ulcer may result in partial or complete obstruction of the pyloric outlet of the stomach with concomitant electrolyte imbalance and fluid deficits. Some cases of obstruction are of a reversible nature in that they are due to pylorospasm and edema at the pylorus, which will be ameliorated, at least in part, by the judicious use of antispasmodics, and perhaps the continuous or intermittent use of suction with a Levine tube in the stomach. Once obstruction on a cicatricial basis has developed, with marked retention of barium four to six hours after its ingestion, and without improvement on a trial of therapy with antispasmodics and intermittent suction, there is no drug which can relieve such a situation and surgery will be necessary. In most cases, subtotal gastric resection will be the operation of choice, although in those elderly patients who no longer have an active ulcer, and whose histamine gastric analysis shows low acid values, a gastro-enterostomy may be adequate. We reserve concomitant vagotomy and gastro-enterostomy for poor risk patients with high gastric acidity, and for those in whom a large inflammatory mass surrounds the ulcer.

5. **GASTRIC ULCER.** The gastric ulcer must be considered as a special problem because of the possibility of the presence of associated carcinoma. For years it has been debated whether these ulcer-cancers are due to sloughing out of the central portion of a carcinoma with acid-peptic erosion of this excavated area, or due to the development of cancer on the basis of chronic irritation. There is much to be said on both sides of this question, but the question itself is strictly academic. Gastric ulcers on the greater curvature of the stomach and in the prepyloric area must be regarded as malignant until proven otherwise by microscopic examination of representative sections of the whole lesion; thus, in these cases, with an occasional exception, gastric resection would be indicated without attempting conservative treatment. The most common variety of gastric ulcer, that situated on the lesser curvature, will be malignant in about 10% of such cases. Gastroscoy, certain x-ray criteria, acid studies, and material obtained from the stomach by the gastric balloon or

papaine technique and studied by Papanicolaou staining methods all will be of some additive value in suggesting the possibility that a given lesion may be benign or malignant, but the final determination will lie in microscopic examination. Moreover, ulcers on the lesser curvature and the posterior wall are likely to erode large vessels with resulting exsanguinating hemorrhage, or are likely to penetrate the full thickness of the gastric wall, eroding the pancreas. Once such penetration has occurred, healing seldom if ever occurs. Large gastric ulcers, even though healed temporarily, as indicated by x-rays, may recur again and again, either because the apparent healing was an indication of filling of the ulcer by granulation tissue or by carcinomatous tissue, or because the thin scar epithelium breaks down again with slight trauma. Consequently, it would seem logical to agree that all gastric ulcers should be attacked surgically if complete healing does not occur in two to three weeks of rigid hospital anti-ulcer therapy. Those ulcers which heal should be closely followed by further x-rays to insure against asymptomatic recurrence. When surgery is undertaken, subtotal gastric resection is indicated, vagotomy and gastro-enterostomy having no place in the treatment of gastric ulcer.

6. *JEJUNAL ULCER.* The jejunal ulcer was

commonly seen, along with its dreaded complication of gastro-jejuno-colic fistula, in the days when gastro-enterostomy was in vogue, but is seen in less than 3% of cases in which a proper subtotal gastric resection is performed, removing the lower three-fourths of the stomach, and utilizing a short jejunal loop for the anastomosis. When such ulcers do occur after gastric resection, vagotomy appears to be valuable in their therapy, but for those ulcers occurring after gastro-enterostomy, gastric resection would be preferable.

SUMMARY

Gastric ulcer is a disease which may threaten the life of the individual in several different ways if it is not eradicated promptly, and thus must be considered primarily of surgical significance. Duodenal ulcer is a disease which frequently can be cured or controlled in its early stages by proper medical measures, but which must be seriously regarded if later complications requiring surgery are to be avoided. The old axiom "once an ulcer patient, always an ulcer patient" still prevails, and all cases handled by surgeons, internists, and general practitioners should be followed carefully for years afterward. Patients who develop repeated recurrences of ulcers, duodenal or gastric, will probably never return to normal health without the benefit of surgical intervention.

IVORY TOWER MEDICINE

It is regrettable that our great medical centers, because they have become citadels of scientific progress, are frequently and thoughtlessly dubbed "ivory towers," with the implication that they have lost the human touch. In speaking of ivory towers I should like to suggest that, if possible, the precious stuff of which the tower is made be forgotten. "Ivory" does for "tower" what "mink" has unfortunately done for "coat." Let us rather emphasize the "tower." One can be lofty without being aloof. A tower is after all a height from which one gets an expanded view of the horizon, a height from which one can still see the achievements of yesterday in the full perspective of the possible accomplishments of tomorrow.

The caption "horse and buggy" doctor by its

very contrast with "ivory-towered medicine" illustrates a major trend that has had and still has a place in providing medical service to the public. Instead of doctors visiting the home, patients now visit the diagnostic clinics and the hospitals. This is especially true in the urban areas. It is not entirely due to a change in attitude on the part of physicians. Often it is not realized that not only is the "horse and buggy" doctor disappearing but also "the horse and buggy home." I wish merely to comment that the factors related to the change in medical service from a "home delivery system" to a "cash and carry" basis are complex and involved. In spite of shortcomings, the new trend is providing better medical care to the population than it has ever had before.

A. E. Severinghaus

J. A. M. A. 155:417

Surgical Management of Peptic Ulcer

CRANSTON W. HOLMAN, M. D.

I should like to summarize for you some of our experiences at The New York Hospital in the surgical management of peptic ulcer.

In spite of the ever-increasing variety of operations available, the surgical therapy of peptic ulcer is still primarily directed towards its complications — namely, perforation, obstruction, hemorrhage, and carcinomatous change. This statement should be qualified, however, by adding that early operation is frequently advocated for gastric ulcer because of the possibility of malignancy, while, conversely, we are reluctant to advise operation for the uncomplicated duodenal ulcer. This general policy results in our operating upon approximately ten per cent of patients who are under treatment.

PERFORATION: The treatment of perforation is immediate operation. There have been several reports in the literature advocating conservative treatment with antibiotics and constant gastric suction, a method that few surgeons recommend.

In any active surgical clinic, it is not an uncommon experience to find at operation the perforated ulcer to be a centimeter or so in diameter, with edges indurated and with gastric contents pouring into the peritoneal cavity—a situation unlikely to be dealt with by nature in a satisfactory manner.

However, in these troubled times, the reports on conservative treatment have served the purpose of establishing a method that can be used to good advantage on small ships at sea where operative treatment is not available.

OBSTRUCTION: The symptoms of obstruction may be due to actual scarring, to edema associated with an exacerbation of an ulcer, or rarely, merely to spasm of the pylorus. These patients should be hospitalized and placed on some form of Sippy regime including vitamins, sedatives, and antispasmodics. Supplemental parenteral fluids are given if indicated. Every evening the stomach is lavaged

in order to determine the degree of retention and so that the stomach may be empty during the sleeping hours. If a pylorospasm is suspected, we have found useful the administration of 1/50 of a grain of atropine, with sodium phenobarbital, as premedication for a gastrointestinal examination. More than once, barium passing freely through a large patent pylorus has proved that a suspected true obstruction is nothing more than pylorospasm. This fortuitous finding has in my experience been limited to those patients with symptoms of recent origin.

Obstruction due to edema should respond to therapy within ten days to two weeks. If the patient's symptoms are of several years duration or if cicatricial stenosis is demonstrated by x-ray, operation is indicated after conservative therapy. One or two weeks of preliminary treatment is advisable so that the size and tone of the stomach may be restored to as nearly normal as is possible and also to allow for correction of any abnormality of the blood constituents.

Gastric resection is the procedure of choice, but it is in this group that gastro-enterostomy may be profitably used in the aged patient or in the presence of coexisting disease which dictates election of the simplest procedure.

We, like others, found that patients with obstruction fared better after operation than those without, and as you know various explanations for this have been proposed. One of the most popular notions predicates that the patients with pyloric obstruction generally have low acidity and therefore after operative relief of the obstruction there is little reason for continued irritation of the ulcer.

Others consider that scarring and obstruction represent the terminal phase of healing and relative inactivity of the ulcer. The latter view is supported by the fact that cicatricial obstruction occurs most frequently in the middle and older age groups, a period of life not so hampered by the aggressive drives and emotional stress of younger ages.

Our studies favor the latter thesis. In a

From the Department of Surgery—The New York Hospital—Cornell Medical College.

group of seventy-five patients, the gastric acidities following gastro-enterostomy were much the same whether or not a pre-operative pyloric obstruction existed.¹ In the post-operative follow up, however, eighty-five per cent of the patients with obstruction had a satisfactory result in contrast to only a sixty-five per cent good result for those without obstruction. Also, except in a very few patients, gastro-enterostomy does not alter the acidity—possibly the major reason for its failure in many cases.

BLEEDING: Bleeding to a dangerous degree is the most common complication of peptic ulcer and, excepting perforation, is the most disturbing. The proper treatment of severe bleeding from peptic ulcer remains a problem for which widely divergent solutions are suggested, and few subjects are more controversial. Different factors influence this wide variation of honest opinion, but, at any rate, it almost invariably leads every large clinic to formulate policies based upon its own experience. This we also have done. During the years 1932 to 1940, all patients were treated by conservative measures, and in a group of 161 patients the mortality was approximately 14 per cent. Each year during this time, we would lose one or two patients who we thought might have been saved by operation to control the bleeding. Because of this, in 1940 we made a critical analysis in the hope of determining what factors were primarily responsible for our poor results. This study,² which led to a change in therapy, I should like to summarize.

It was found that conservative treatment led to a high mortality in the following two types of patients. (1) Those who continued to bleed massively for forty-eight hours in spite of rigid conservative treatment; (2) Those with previously uncomplicated ulcer who started to bleed in the hospital while receiving supposedly optimum medical therapy.

In addition, since most of the patients in these two groups were over forty years of age, it followed that the older the patient—the higher the mortality.

THE POLICY OF IMMEDIATE SURGICAL INTERVENTION IN CERTAIN CASES: These findings led to a policy of immediate operation for patients of the two types

mentioned above, and, since 1940, the mortality rate has been reduced to five-plus per cent. This gratifying decrease is attributed with some confidence to the promptness of operation since other variables that might influence results remained unchanged. During both periods all patients were of the ward class, interpretation of the severity of hemorrhage was determined by the same standards, and surgery was performed by supervised resident surgeons, all trained by the same methods. To be sure, although the general policy dictates immediate operation for these two types of patients, it is realized that no hard and fast rules can be routinely followed when treatment is outlined for each individual patient. For instance, one patient, several days after being admitted to the hospital because of hemiplegia, developed relentless upper gastrointestinal bleeding, but his poor general condition as a result of his paralysis precluded operative treatment.

Brief comment should be made about what influence the location of the ulcer and additional coincident complications may have upon treatment. Sandusky and Mayo³ report a mortality for gastric and duodenal ulcer of 30 per cent and 5.4 per cent respectively—a more striking difference than that encountered in our experience.

Bleeding from a marginal ulcer secondary to either gastric resection or gastro-enterostomy is not so serious as that from a primary ulcer. This is probably best explained by the fact that many times the secondary ulceration occurs in the jejunal side of the anastomosis where the vessels are relatively small. However, on rare occasions, immediate operation is indicated in cases of terrific bleeding when it appears obvious that some large vessel has been eroded. One such patient came under our care and died rather quickly after having bled fitfully for seven days. At autopsy it was found that a large anastomotic ulcer had eroded the superior mesenteric artery.

The simultaneous or immediately successive complications of perforation and hemorrhage are particularly serious and offer rather a dismal prognosis. Either combination, perforation and then bleeding or bleeding and then perforation, is best treated by gastric resection in

spite of the technical difficulties that may be encountered.

MANAGEMENT OF SERIOUS GASTRO-INTESTINAL HEMORRHAGE: In our present management of serious gastro-intestinal hemorrhage, preliminary steps include the placing of the patient in a hospital, early consultation between physician and surgeon, and immediate arrangement for transfusions. All patients are first placed on a conservative regimen, which includes complete bed rest, sufficient sedation to keep the patient comfortable and free from anxiety, adequate blood replacement to maintain a normal blood volume, and, for the first few hours of observation, nothing by mouth. This routine is followed with a definite purpose.

In the first place, patients who bleed are apprehensive and agitated, which contributes to their general restlessness. It is important to reassure them, to provide quiet surroundings, and to make them as comfortable as possible.

In the second place, immediate blood replacement should be begun. There is no evidence to support the belief that giving a blood transfusion will increase the patient's blood pressure to a point that might stimulate the recurrence of bleeding. Costello⁴ emphasized the importance of administering large amounts of blood, and considered this practice responsible for the mortality rate of less than 5 per cent that he attained in a group of seventy-six patients treated for massive upper gastro-intestinal hemorrhage due to a variety of causes.

Third, the policy of withholding everything by mouth during the first few hours of observation is recommended because occasionally when fluids and food are allowed hematemesis recurs. After the patient becomes accommodated to his new surroundings and the first excitement of hospital admission has passed, the decision whether or not a restricted diet is to be given should be determined by whether or not the patient is hungry. This simple rule fulfills most of the theoretical factors involved in determining whether or not the stomach containing food is less likely to bleed. Hunger pains indicate existent motility of the stomach, which can be reduced or eliminated by feeding. On the

other hand, in patients who are nauseated or who do not wish food, feeding may initiate vomiting and contribute to a recurrence of bleeding.

Immediate surgery during the period of active hemorrhage should be considered only after the diagnosis of ulcer has been established beyond reasonable doubt since a variety of conditions share bleeding as their most prominent symptom. Usual causes for bleeding other than ulcer, such as esophageal varices, the blood dyscrasias, and carcinoma, can be readily determined. In addition, if there is real doubt as to whether the bleeding originates from an ulcer and if no other cause for the bleeding is apparent, operative treatment is not indicated. It cannot be over-emphasized that once operation is decided upon for a patient, the sooner it is undertaken the better, since, as Finsterer⁵ has shown, the operative mortality varies directly with the duration of bleeding. To delay in the hope that the bleeding will stop is dangerous—certainly every one expresses pessimism for those who fail to improve after prolonged conservative treatment and who are operated upon as a last resort.

If operation is decided upon, gastric resection is the procedure of choice, to ensure both immediate control of bleeding and a satisfactory permanent result; and, although it may seem a formidable procedure in a person debilitated by blood loss, it is surprisingly well tolerated.

Occasionally when we are doubtful about the cause of bleeding but feel that an ulcer is responsible, a limited gastric x-ray examination may be useful. In this event, the operating-room is alerted when the patient is taken for the x-ray study, and if ulcer is found, the patient is taken directly to the operating-room.

When operation is planned in a patient in whom ulcer is suspected even though there is no x-ray evidence, the surgeon is faced with the possibility of being unable to locate the bleeding point. Of over 400 cases observed at operation or autopsy, in only five was it impossible to locate the source of bleeding. But, however slight the possibility, failure to find the source of hemorrhage even after gastrostomy is a most frustrating experience. Some judge that, in spite of such a failure, gastric

resection should be done; with this I cannot agree. As an alternative, ligation of all of the vessels along the lesser curvature of the stomach is recommended.

Finally, what happens to those patients, approximately 87 per cent, who recover from their bleeding under a conservative regimen? Our findings, and those of others, reveal that over 50 per cent of these patients will bleed again, and 75 per cent will have symptoms that require medical attention. These are potent arguments for surgical therapy, and, although each individual case must be judged on its own merits, it would seem reasonable to advise operation on those patients over 40 years of age who have bled from an ulcer that has been recurrently active for a period of years.

In summary, then: Patients who bleed should be hospitalized and placed on a conservative regime. If, after 48 hours, bleeding continues, operation is indicated, particularly if the patient is over 40 years of age. Immediate operation should be performed on those patients who begin to bleed in the hospital while they are being treated for a previously uncomplicated ulcer.

GASTRIC ULCER

Because of the ever-present threat of malignancy in every gastric lesion, the uncomplicated gastric ulcer, in contrast to the duodenal ulcer, is always considered a possibility for early surgical treatment. This policy of early operation upon gastric lesions developed from the experience that an *incorrect* differential diagnosis between carcinoma and benign ulcer occurred too often to warrant conservative treatment over a long period of time.

About fifteen years ago a review⁶ of our proved gastric lesions emphasized the difficulty of establishing a correct diagnosis. We found that it was impossible by any *single* method to make a definite diagnosis in approximately fifteen per cent of the patients.

It should be emphasized that this figure does not represent mistakes in diagnosis but rather the inability to conclusively establish the correct diagnosis. Nor does this finding represent mistakes in therapy; most cases were treated properly, since one or more of the diagnostic procedures pointed to the correct diagnosis.

This study did prove, however, that if any single method of examination indicated the presence of malignancy—such as, a palpable mass, an x-ray suggestive of cancer, or an anacidity—immediate removal of the lesion was indicated.

Also, these findings emphasized that all methods of diagnosis should be used and, in particular, I wish to mention the gastric analysis—an examination that at the present time has been all but abandoned by some. Bloomfield and Pollard⁷ demonstrated its usefulness if the test was done carefully, and they found, as have others, that a benign lesion is so rarely associated with an anacidity that, whenever a gastric lesion is associated with an anacidity, it must be considered malignant until proved otherwise by microscopic examination.

Case Report: A 54-year-old woman had symptoms of indigestion for several years, negative physical findings, and an x-ray that revealed a gastric ulcer on the lesser curvature. On two occasions, an anacidity was found by gastric analysis. On conservative therapy, the patient's symptoms disappeared, the ulcer became smaller and then the patient failed to return to the clinic until five months later when her symptoms recurred. X-ray examination at that time revealed a recurrence of the ulcer with some characteristics of malignancy. The patient finally agreed to operation and at operation a carcinomatous ulcer was removed. In this case, the anacidity was the only early indication of a malignancy.

SUMMARY

Perforation of a peptic ulcer should be surgically treated.

Cicatricial pyloric obstruction is best treated by gastric resection. However, it is in this type of patient, that simple gastro-enterostomy may be useful.

Massive bleeding from a peptic ulcer should be considered an indication for immediate operation if (1) the patient continues to bleed for over 48 hours, (2) the patient begins to bleed while in the hospital receiving treatment for a previously uncomplicated ulcer.

Surgical therapy should be considered for all gastric ulcers. Immediate operation is indicated if any examination suggests malignancy or if the ulcer fails to show evidence of

healing within a month's time.

BIBLIOGRAPHY

1. Holman, Cranston and Sandusky, William R.: Gastric Acidity after Gastro-enterostomy. American Journal of the Medical Sciences, V. 195, No. 2, P 220, 1938.
2. Holman, Cranston W.: Severe Hemorrhage in Gastric and in Duodenal Ulcer. Archives of Surgery, V. 40, P 150, 1940.
3. Sandusky, W. R., and Mayo, H. W., Jr.: The Management of Severe Bleeding from Gastric, Duodenal and Jejunal Ulcers. Southern Surgeon, V. 15, P 69, 1949.
4. Costello, C.: Massive Hematemesis—Analysis of 300 Consecutive Cases. Annals of Surgery, V. 129, P 289, 1949.
5. Fristerer, H.: Operative Treatment of Severe Gastric Hemorrhage of Ulcer Origin. Lancet, V. 2, P 303, 1936.
6. Holman, Cranston W., and Sandusky, W. R.: Further Observations on the Diagnosis and Treatment of Gastric Lesions. Annals of Surgery, V. 112, P 339, 1940.
7. Bloomfield, A. L., and Pollard, W. S.: The Diagnostic Value of Studies of Gastric Secretion. J.A.M.A., V. 92, P 1508, 1929.

SOUTH CAROLINA MEDICAL ASSOCIATION COMMITTEES 1954-55

COMMITTEE ON SCIENTIFIC PROGRAM:

Dr. Henry W. Mayo, Jr., Chairman ----- Charleston
Dr. William Schulze ----- Greenville
Dr. Richard B. Josev ----- Columbia
Dr. Rowland F. Zeigler ----- Florence
Dr. Robert Wilson, ex-officio ----- Charleston
Dr. Thomas R. Gaines, ex-officio ----- Anderson

COMMITTEE ON VETERANS MEDICAL CARE:

Dr. Lawrence P. Thackston, Chairman ----- Orangeburg
Dr. James T. Green ----- Columbia
Dr. Bachman S. Smith, Jr. ----- Charleston

COMMITTEE ON MATERNAL WELFARE:

Dr. Frank Geibel, Chairman ----- Columbia
Dr. J. P. Booker ----- Wallhalla
Dr. Sam Garrison ----- Johnston
Dr. Hiram B. Morgan ----- Ware Shoals
Dr. Hilla Sheriff ----- Columbia
Dr. Heyward Fouche ----- Columbia
Dr. J. W. Snyder ----- Sumter
Dr. David Watson ----- Greenville
Dr. Lawrence Hester ----- Charleston

COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS:

Dr. David F. Adcock, Chairman ----- Columbia
Dr. C. R. F. Baker ----- Sumter
Dr. M. J. Boggs ----- Abbeville
Dr. Norman O. Eaddy ----- Sumter
Dr. W. Wyman King ----- Batesburg
Dr. John C. Sease, ex-officio ----- Newberry
Dr. Robert Wilson, ex-officio ----- Charleston
Dr. Thomas R. Gaines, ex-officio ----- Anderson

MEDIATION COMMITTEE (FORMERLY GRIEVANCE COMMITTEE):

First District
Dr. J. A. Siegling, Secretary ----- Charleston
Second District
Dr. Weston C. Cook, Vice-Chairman ----- Columbia
Third District
Dr. R. Brooks Scurry ----- Greenwood
Fourth District
Dr. Thomas G. Goldsmith ----- Greenville
Fifth District
Dr. Roderiek MacDonald, Chairman ----- Rock Hill
Sixth District
Dr. Walter R. Mead ----- Florence
Seventh District
Dr. Norman O. Eaddy ----- Sumter
Eighth District
Dr. Wilbur R. Tuten, Jr. ----- Fairfax
Ninth District
Dr. James H. Sanders ----- Gaffney

COMMITTEE ON SCHOOL HEALTH:

Dr. John R. Paul, Jr., Chairman ----- Charleston
Dr. Robert C. Brownlee ----- Greenville

Dr. George Robert Dawson ----- Florence
Dr. Robert Lee Sanders ----- Columbia
Dr. E. W. Tucker ----- Greenwood
Dr. Hilla Sheriff, ex-officio ----- Columbia

COMMITTEE ON CANCER:

Dr. J. R. Young, Chairman ----- Anderson
Dr. John C. Hawk, Jr. ----- Charleston
Dr. R. C. Horger ----- Orangeburg
Dr. M. Ed Parrish ----- Sumter
Dr. Harold S. Pettit ----- Charleston
Dr. T. A. Pitts ----- Columbia
Dr. Henry H. Plowden ----- Columbia
Dr. Furman T. Wallace ----- Spartanburg
Dr. John K. Webb ----- Greenville

MEMORIAL COMMITTEE:

Dr. George R. Wilkinson, Chairman ----- Greenville
Dr. Kenneth M. Lynch, Jr. ----- Charleston
Dr. George W. Truluck ----- Orangeburg

COMMITTEE ON PUBLIC HEALTH:

Dr. W. Atmar Smith, Chairman ----- Charleston
Dr. Clyde F. Bowie ----- Anderson
Dr. R. L. Crawford ----- Lancaster
Dr. Carroll J. Scurry ----- Greenwood
Dr. William R. Wallace ----- Chester

COMMITTEE ON GAMMA GLOBULIN DISTRIBUTION AND POLIO VACCINE:

Dr. Joseph I. Waring, Chairman ----- Charleston
Dr. Weston Cook ----- Columbia
Dr. T. G. Goldsmith ----- Greenville
Dr. Walter Hart ----- Florence
Dr. Wyman King ----- Batesburg
Dr. Ben Miller ----- Columbia
Dr. G. E. McDaniel, ex-officio ----- Columbia

COMMITTEE ON HISTORICAL MEDICINE:

Dr. Joseph I. Waring, Chairman ----- Charleston
Dr. Chapman Milling ----- Columbia
Dr. R. M. Pollitzer ----- Greenville

COMMITTEE ON INFANT MORTALITY:

Dr. Joseph I. Waring, Chairman ----- Charleston
Dr. Herbert M. Black ----- Columbia
Dr. John C. Bonner ----- Charleston
Dr. William A. Hart ----- Columbia
Dr. Ethel M. Madden ----- Columbia
Dr. Hervey W. Mead ----- Pendleton
Dr. Keith F. Sanders ----- Kingstree
Dr. Robert Lee Sanders ----- Columbia

COMMITTEE ON MEDICAL AND HOSPITAL INSURANCE CONTRACTS:

Dr. Joseph P. Cain, Chairman ----- Mullins
Dr. E. D. Guyton ----- Florence
Dr. R. W. Hanckel ----- Charleston
Mr. M. L. Meadors, ex-officio ----- Florence

(Cont'd. on page 281)

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain ----- Mullins
J. D. Guess ----- Greenville
C. J. Milling ----- Columbia
H. R. Pratt-Thomas ----- Charleston

Vince Moseley ----- Charleston
Ben Miller ----- Columbia
W. H. Prioleau ----- Charleston
J. W. Jervey ----- Greenville

G. D. Johnson ----- Spartanburg
R. M. Pollitzer ----- Greenville
Hugh Smith ----- Greenville
Walter Mead ----- Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Charleston, S. C.

Subscription Price

\$3.00 a Year

SEPTEMBER, 1954

Charity at Home

Were the physician to respond by giving to every cause whose appeal comes to his desk, he would have to be rich as Croesus and generous in proportion. Often he would be giving to spurious efforts and would be lining the pockets of enterprising promoters.

An appeal from united community campaigns, the "Red Feather" and such, implies an endorsement of the worthiness of the participating agencies and organizations. It asks for a lump sum, it offers one appeal instead of the many which we formerly heard, it saves our time and effort and the labors of a host of volunteer workers. It is organized, supervised, justified charity.

Often a physician feels that he makes intangible contributions in unrequited professional services, and should not be expected to give to community campaigns. Such services are a normal part of his calling and are to be expected from all true physicians. They do not relieve him of the responsibility of helping materially insofar as he can with civic charities.

The physician is not a big benefactor of organized community efforts. The average physician gives about \$48.00 to "chests" and \$74.00 to funds, but only six out of ten give at all to chests and only eight out of ten give to funds.

We could do better, without pain.

Naturopaths Bring Suit

The situation with respect to the practitioners of naturopathy in South Carolina seems to be approaching a climax, with the initiative being taken by the naturopaths themselves. On June 22, 1954, suit was in-

stituted against the Attorney General of South Carolina in the Court of Common Pleas for Spartanburg County by M. S. Dantzler and J. D. Branyon, described respectively as the president and secretary-treasurer of the State Naturopathic Physicians Association. In this proceeding they seek a declaratory judgment of the Court, interpreting the statutes of the State as conferring upon licensed naturopaths the right to prescribe, dispense and administer "all drugs of botanical origin, including opium and all of its derivatives." The Complaint alleges that the naturopaths "are being arbitrarily, unjustly, and unlawfully . . . limited and restricted in a manner not warranted by law," as the result of various opinions rendered from time to time by the present Attorney General, T. C. Callison, and his predecessor-in-office.

The statutes clearly do not give any specific authority to the naturopaths to do the things they claim and the Attorney Generals, past and present, have so ruled on more than one occasion. Their contention now seems to be that such authority is to be implied from the use of various terms included within the definition of Naturopathy, as carried in the original statutes and the amendments. The Complaint in the case alleges that the naturopaths are fully qualified by training and education to deal in these drugs, and that through the opinions of the Attorney General, referred to, "their rights, privileges and immunities (have been) destroyed, hampered and illegally interfered with."

The proceeding is patterned after one instituted by the naturopaths in Florida more than a year ago and completed early this year upon the decision by the Supreme Court of

that State, after a second hearing on appeal. The appeal originally was determined against the naturopaths but petition for rehearing was granted and following argument the second time, the Florida Court reversed itself and held in favor of the contention of the naturopaths there. In April of this year the Attorney General of Florida rendered an opinion consistent with the final decision of the Supreme Court and the naturopaths in that State apparently now are authorized to do the things for which they seek authority in South Carolina.

The Executive Secretary and Counsel of the South Carolina Medical Association received information about a year ago that some such proceeding probably would be brought. He brought it to the attention of Council at its meeting in September 1953, and at that time was authorized, in the event suit were brought, to file a brief *amicus curiae* and to take further action on the Association's behalf if indicated. Obviously, commencement of the proceeding in South Carolina was postponed until after final determination of that in Florida, and the result there will probably be pressed strongly as a precedent in the South Carolina case. It will not, of course, however be binding upon the Courts in this State.

Immediately after the institution of the proceeding, the Association's legal counsel conferred at length with the Attorney General, and in view of his knowledge of the general situation and interest in the matter on behalf of the Association, was requested to be associated with the Attorney General's office in the defense of the suit. We were able to place in the hands of the Attorney General considerable background material and information concerning the Florida case, which apparently may be of considerable value.

A Demurrer to the Complaint has been filed on behalf of the Attorney General, this pleading being designed to test the strictly legal basis for the action and the Plaintiffs' right to maintain it. It takes the position, briefly, that the statutes are entirely clear in their provisions, that they mean what they say, and that under no reasonable or proper interpretation can their language be construed to extend the authority of the naturopaths to the lengths

suggested. The matter will be heard by a Circuit Judge in Spartanburg, probably during the early part of September. If the Demurrer is sustained, that will end the matter so far as the present action is concerned, except of course, for the probability of an appeal to the Supreme Court. If the Demurrer is overruled, the Court will doubtless allow the Defendant to answer, and thereafter, additional issues will unquestionably enter the proceeding—issues of fact as well as law—which will be determined by the Court in a subsequent hearing.

Attorneys for the Plaintiffs are Sam R. Watt and T. E. Walsh of Spartanburg; and for the Defendant, T. C. Callison, Attorney General, James S. Verner, Assistant Attorney General, and M. L. Meadors.

The naturopaths during the past several years have broadened their field of activity considerably, and to such an extent that many of them now exercise virtually the same prerogatives of practice as those rightfully held by doctors of medicine. If the Court should hold in line with their contention in the present suit, it would be hard indeed to distinguish any line of demarcation between their rights of practice and those of the doctors of medicine.

For the benefit of the public, therefore, it seems that the medical profession should take a positive stand and discharge its responsibility in giving the Attorney General and the Court full information concerning the actual situation, particularly as it concerns the background of medical training and experience of the holders of the licenses to practice naturopathy. While the Association is not in name a party to the suit, its interest therein and support of the position of the Attorney General will be clearly understood. The Chairman and other members of Council have been consulted from time to time on the action taken thus far, which, as stated above, is in line with the official action directed by Council nearly a year ago.

In other phases of the same matter, it will be recalled that Resolutions were adopted by several county and district medical societies this spring, calling upon the Attorney General to use the facilities of his office in making a

thorough investigation of the schools or institutions furnishing whatever scientific training and education the naturopaths may have, so as to determine, if possible, the basis of their right to license as practitioners of a healing art. Prior to commencement of the action, it is understood that the Attorney General had called upon the Secretary of the Board of Naturopathic Examiners for a list of the licensees in the State and that this request had been partially complied with.

In the latest development which has come to our knowledge, the Barnwell County Medical Society, on June 25, went on record by unanimous vote to call the situation to the attention of that County's long-time, prominent member of the House of Representatives, Speaker Solomon Blatt. The Barnwell County physicians, through their secretary, state that, "as doctors of medicine, we regard this increase (of naturopaths) with foreboding, realizing . . . that the citizens of our State are ever increasingly exposed to that which we consider inferior medical care in all its details." The letter calls attention further to the fact that naturopaths are licensed in only about eight states, and that the laws under which they were formerly licensed in Tennessee were repealed in 1947.

The action of the Barnwell County Medical Society calls for repeal of the law in South Carolina and requests the cooperation of Mr. Blatt in that effort. Activity directed toward the same general end in the past years has met with very good success in the House of Representatives. The Senate of South Carolina is where the chief difficulty has always arisen, and will probably arise again.

M. L. Meadors

A Judgment for Solomon

Concern for the child with cerebral palsy has increased greatly in recent years, and many efforts have been made toward remedial action. Especially has the National Society for Crippled Children and Adults worked toward the betterment of educational and therapeutic conditions, and its constituent, The Crippled Children Society of South Carolina has concentrated primarily and very successfully on measures to aid the palsied child. Through

the sale of Easter Seals, funds have been raised for an ever-expanding program and activities are carried out in many parts of the state.

Lately there has appeared on the local scene another national organization known as the United Cerebral Palsy Association, an organization approved for fund raising and proposing to aid the palsied child by material benefit and by research. One fourth of the funds raised goes for the latter purpose. The rest goes for local effort as determined by local chapters, of which one or more have been already organized in the state. The Crippled Children Society likewise has a provision for research, but nine-tenths of its funds are expended in the area in which they are raised.

It is doubtful that anyone will question the desirability of raising funds to help the palsied child, and surely the field for research is wide and inviting. But there is a danger that in heeding the sentimental and emotional appeal which must carry much weight in a desire to help the child the interested person will overlook or disregard certain practical considerations.

One of these is the near certainty of confusion and competition between two organizations aiming at the same goal. Already the public is confused and no doubt many of the physicians are vague in their conception of the relations of the societies. Multiplication of drives and appeals will bring further confusion and perhaps divide interest and money necessary to the success of any campaign. Existence of competitive chapters in communities will not be helpful in running smooth programs, and the expenditure of efforts and funds in conducting campaigns will be duplicating and confusing.

The United Cerebral Palsy Association has come into South Carolina without an announced specific program, without consultation with the active and long established Crippled Children Society, and without preliminary conference with the State or County Medical Societies. It has preceded to set up chapters and to conduct a highpressure, big business type of collection campaign in one community. It has no data to indicate the needs which its funds might satisfy, it has no

medical advisory committee on the state level, it has no definite statements as to its future relations with other organizations. Indeed in our opinion its approach has been devious and its gilding of the quoted word has been most questionable. Whatever its final aims may be, its approach has not been pleasing to those who have followed developments closely.

It may be that our information does not cover all aspects of this present conflict. It may be that better relations can be developed and that a cooperative enterprise may result in a well coordinated approach to the goal which is the same for both organizations. We quarrel with the method, not with the end.

Meanwhile, is such an organization to supplant or injure an older established body which has worked hard and conscientiously to improve the lot of the palsied child? Scripture does not say whether the judgment of Solomon involved a healthy child or one afflicted. It would seem not difficult to guess what his judgment would be in this present instance.

Blue Cross — Blue Shield

The Executive Director and I have recently studied analytically over 200 bills submitted by hospitals to the Blue Cross Plan. These bills had raised some question in the Claims Department.

What we found was quite interesting, rather surprising, and helps to explain why subscription charges, based on expected average utilization, hospitalization only when hospitalization is indicated, and expected average x-ray and other laboratory examinations and expensive drugs, have failed to meet the costs of hospital care for our subscribers. It also helps explain why there is a general complaint against the high cost of hospital care.

Let me mention briefly some things we found during a study of those bills.

The operating room charge for circumcision of a six-year-old boy was \$30.00 in one hospital and was \$20.00 in another—surely not the doctor's fault, but seeming excessive charges.

Two children were hospitalized for treatment of intestinal worms—one of round

worms and one of hook worms. The round worm case was kept in hospital eleven days, and the hospital bill amounted to \$89.60. The hook worm case was hospitalized for 4 days.

There was a small group of cases hospitalized with a diagnosis of pyelonephritis. They were kept in hospital two days, at a cost for each of over \$69.00. Apparently they were hospitalized for cystoscopy and pyelograms. However, neither the admitting diagnosis nor the hospital bill intimated that they were hospitalized primarily for diagnostic study.

A case of appendicitis, hospitalized for six days received \$8.00 worth of drugs, but x-ray examinations were charged at \$85.00 and laboratory fees amounted to \$69.00.

A case admitted as acute hepatitis was kept in hospital only one day. A case of "back strain," hospitalized for three days, received x-ray examinations costing \$20.00. Laboratory fees amounted to \$17.50. X-ray charges for a case of intermittent tachycardia were \$50.00. One case of nephrolithiasis received x-ray examinations costing \$90.00. One case with an admitting diagnosis of nervous exhaustion was charged \$35.00 for x-ray examinations.

Investigation has revealed several things: many admitting diagnoses were not the final diagnoses. There can be no fault with that, but frequently the given admitting diagnosis appears to have been an effort to justify hospitalization for treatment, when in fact it was primarily for diagnosis. Some of these cases could have been handled just as well as outpatients.

X-ray examinations were made frequently at the request of the patient and had no bearing upon the condition for which he was receiving treatment.

Hospitalization was demanded by some patients in order, as they admitted, to save them the cost of expensive drugs. At least some of these hospitalized conditions are ordinarily treated as ambulatory office cases.

As long as human nature is what it is, efforts will be made to coerce doctors to order hospitalization and to order examinations and treatments which are not needed. It presents a difficult problem to us doctors. That being the case, the admitting diagnosis should be so stated as to indicate *why* the patient was hos-

pitalized rather than to state a comprehensive diagnosis—fever, severe pain, shock, for cystoscopy, for operation, for blood transfusions, etc. X-ray examinations, EKGs, and laboratory examinations not consistent with the diagnosis and not necessary but simply coincidental with the treatment should be so labeled so that the hospital may charge the patient for these non-covered services.

Patients won't like it, I admit. However, it is not fair to allow a few greedy people to wreck the Blue Cross Plan or drive its charges so high that those who need Blue Cross most cannot afford it.

There is no desire to deny anyone the hospital services he needs, nor to criticize nor restrict the doctor's management of any case. On the other hand, it is necessary that the cost of the services paid for by the Plan does not exceed its subscription income. It is felt that already subscription charges have reached the stage of diminishing returns. To raise them again would not only drive out of the Plan many who need it most, but it would so increase the per capita cost of administration that the balance left for payment for hospital services would not be greater than now.

An effort is being made to impose more strictly the waiting periods, the demand that x-ray and other examinations be consistent with the diagnoses before they are covered, the rule against hospitalization for domiciliary care, and the reduced liability of the Plan for hospitalization primarily for diagnostic studies. To do this requires considerable correspondence by the Plan, the member hospitals and the doctors. This is expensive and troublesome, and delays the payment of hospital bills.

Some changes in coverage and administration that are being considered: A more complete and accurate statement of diagnosis before hospital services are authorized; a limitation of the liability of the Plan for drugs and medications; a restriction of liability for costs of x-ray studies to the percentage of such charges retained by the hospital under terms of its contract with the radiologist; a routine deduction of some amount from the costs of each hospitalization (perhaps the cost of two days board and room charges or some fixed

routine deduction).

What will ultimately come out of these considerations, the writer does not know. However, necessity knows no compromise. The just obligations of the Plan must be paid. Those obligations must either be further limited and restricted, or what appear to be abuses must be terminated.

J. Decherd Guess, Medical Director

Blue Cross - Blue Shield

Waiting Periods

No feature of the Blue Shield and Blue Cross contracts is less understood by the doctors and the members than is the imposition of a waiting period of one year before the treatment of pre-existing surgical and medical conditions is covered. Neither is there a feature which gives rise to more complaint, bickering, and disappointment and eventually to more ill will.

Even though the requirement of a waiting period has all of those faults, it is absolutely necessary. There are two important things to remember about it. The first is that after a year's membership, all illnesses covered by the agreement become covered even though they may have been present at the time of joining the Plan and they remain covered during the individual's lifetime, provided he continues to pay his dues. He is privileged to continue his membership on a direct billing basis even after retirement or withdrawal from the group.

The second thing to remember is that by imposing a waiting period for pre-existing conditions, the cost per member is much lower than it necessarily would be if there were no waiting period.

In large groups, which were not organized primarily to secure group insurance, and particularly in large groups of healthy industrial workers, the waiting period can be eliminated. The cost of treatment of pre-existing conditions spreads so thinly through the group that the increased cost per contract is not excessive. Similarly, groups that have already been insured by a commercial carrier for a year or longer, presumably have had already existing illness cared for, and the waiting period requirement may be waived.

Small groups, and particularly small groups in which only a part of the group applies for membership, and individual applicants are likely to be weighted against the Plans. Individuals who know or suspect that they will need early treatment will surely wish pro-

tection against the cost of such anticipated treatment. The Plans must of necessity either deny membership to these seekers of benefits for which they do not pay or they must institute protective barriers against what otherwise would be certain loss. The waiting period is one such barrier.

Our Blue Cross Plan writes into the subscription agreement the waiting period provision in rather general terms. It reads:

"Hospital services will not be provided during the first twelve (12) months of membership for any ailment, disease or condition existing on the effective date of the Subscription Agreement, or for which medical-surgical treatment or advice was rendered within one year prior to such effective date."

It is not necessary that the subscriber know of such a diseased condition, or that either a tentative or a positive diagnosis has been made or that he has received treatment for it within one year.

Either diagnosis by a doctor, medical treatment or recognition of symptoms of a disorder by either the doctor or the patient makes the application of the waiting period mandatory.

Also when no symptoms have been recognized, no diagnosis has been made and no treatment has been received, if the nature of the disease is such as to presumptively indicate that it had its beginning before the effective date of the agreement, the waiting period will be applied.

Worsening of a pre-existing condition or complications arising in connection with it do not remove the waiting period requirement.

Any one of the following conditions without definitive history to the contrary will be considered to have been pre-existing: warts, moles, nevi, skin blemishes, scars, hemangioma, lymphangioma, superficial cysts, lipoma, peptic ulcer, gall stones, chronic cholecystitis, kidney stones, fibroid tumors of the uterus, retroversion and prolapse of the uterus, cystocele, rectocele, urethrocele, perineal laceration, ovarian cysts, congenital defects, deformities and anomalies, allergies, asthma, arthritis, tuberculosis, diabetes, hay fever, neoplasms, chronic appendicitis, deviation of nasal septum, valvular heart disease, vascular disease, varicose veins, hypertension, prostatitis, prostatism, prostatic obstruction, toxic goiter and myxedema.

The Blue Shield Subscription Agreement has both a general protective paragraph against pre-existing conditions, similar to that in the Blue Cross contract, and also spells out in detail certain surgical conditions which by designation require a waiting period of one year.

Exceptions to exclusion of pre-existing conditions cannot be made without endangering the financial stability of the Plans. In most instances, their treatment is elective and can be safely postponed until the waiting period has expired.

J. D. Guess



Forty Years Ago

SEPTEMBER 1914

A vital statistics law had finally been passed, after continued efforts of the South Carolina Medical Association since 1848! Announcement of the approaching opening of the new Medical College building was made. A paper propounded the bacterial origin of pellagra. The Journal refused unethical advertisements. The Health Department obtained from the legislature a sum of \$10,000 for establishing a sanatorium for tuberculous patients.

CORRESPONDENCE

Hartsville, South Carolina
August 23, 1954

The Editor

Journal of the South Carolina Medical Association

Dear Sir:

The work of the Crippled Children Society of South Carolina and its County Chapters has been planned and conducted throughout the state with the advice and counsel of the Medical Profession. The State Medical Advisory Committee advises the Society on programs and policies affecting the State as a whole, and County Medical Advisory Committees advise County Chapters on particular projects and programs in the larger counties. In the smaller counties, the advisory service of the doctors is informal but nonetheless valuable and helpful.

The cooperation and interest of State and County Medical Societies in the work of the Crippled Children Society of South Carolina and its County Chapters have been almost 100 per cent throughout the State. There is recognition on all sides of a common objective of helping crippled children and that such help, to be effective, must stem from professional diagnosis and treatment. The Crippled Children Society of South Carolina and its entire membership throughout the State are grateful to the Medical Pro-

fession for the priceless help and interest of the doctors throughout the State in the work of the Society.

The Crippled Children Society of South Carolina has suddenly become confronted with what appears to be a serious threat to its program of expanding service to crippled children in this state. Five years ago, the Society undertook the additional responsibility of serving, among others, the cerebral palsied. Clinics and treatment centers were set up and are being maintained throughout the State with the cooperation of the doctors and numerous service organizations. Plans are under consideration for further expansion of these services.

The policy of the Society has been to raise its funds primarily from an Easter Seal Sale Campaign once a year. This campaign is conducted largely by volunteer workers and through the cooperation of many service organizations. 91.2 per cent of the funds raised remain in the state, 8.8 per cent being devoted to crippled children work on a National level. The cost of raising funds for the crippled children work in this state, including supplies, stamps, etc., is about the lowest of any fund-raising campaign for any health program, because the work is done largely by volunteers without compensation. The total budget for the State Society and all local County Chapters, including the amount contributed to the National organization for the current year is \$132,000. While this amount is comparatively small, very little of it goes to administrative expenses, the preponderant proportion being used to provide direct services and help to crippled children.

Now suddenly comes into South Carolina an organization under the name of United Cerebral Palsy Associations, Inc., which has expanded rapidly throughout the United States in the five years since it was set up, with the announced intention of organizing local affiliates in every county of 50,000 population or more. United Cerebral Palsy, as the name implies, is devoted primarily to serving the cerebral palsied. The organization is under able leadership, it has a program of large and fast expansion, its services in the field of cerebral palsy are worthy and in particular its substantial research program into the causes, treatment and prevention of cerebral palsy. The UCP has received National recognition. It conducts no annual money-raising campaign but carries on from time to time in different communities money-raising efforts, some of which are of a spectacular nature. Of all the funds raised, one-fourth goes to National Headquarters in New York. Of this 25 per cent, about 6 per cent is used for research.

The UCP organization came into this state by setting up a telethon money-raising project in Greenville, which the organization reported to have raised a gross amount of \$70,000. This money-raising project was largely a professional one, and there has been no public report as to the cost and expenses of raising this amount. Efforts are now being made to set up affiliates in Spartanburg, Columbia, Charleston and four or five other cities throughout the state.

The concern of the Crippled Children Society of South Carolina and the County Chapters, as well as other volunteer organizations that are helping in the work with the cerebral palsied, arises from the facts that:

(1) Duplication of money-raising efforts in this State to serve the needs of the cerebral palsied and other crippled children will cause confusion to the public and possibly some irritation over multiple demands for funds for the same type of service;

(2) The United Cerebral Palsy Organization has come into South Carolina and is setting up affiliates that are not in response to any request on the part of the people of the State for additional and unmet services not now being rendered by the Crippled Children Societies;

(3) The UCP undertook its organizational program in this state without any survey as to what the needs of the cerebral palsied might be or as to the services being rendered by the Crippled Children Societies and other organizations to the cerebral palsied and without any consultation or conference with officers or staff of the Crippled Children Society of South Carolina. It was only after repeated efforts on the part of the officers of the Crippled Children Society to find out what the purpose and program of UCP was in South Carolina and after the UCP found it difficult to organize local affiliates that representatives of UCP conferred with the officers of the Crippled Children Society.

The dilemma in which the Crippled Children Society of South Carolina and its County Chapters find themselves is that they do not want to be put in a position of opposing a Nationally recognized organization that is devoted to the service of the cerebral palsied when such service is one of the major concerns of the Crippled Children Society. On the other hand, it is generally felt that there is no need for two organizations throughout the state serving to a large extent the same field of service with resulting duplications, complications, etc. The UCP insists that it does not want the Crippled Children Society to retire from its service to the cerebral palsied but on the other hand desires to avoid any duplication of effort. The position of the Crippled Children Society of South Carolina is that no additional organization is required to serve the needs of the cerebral palsied and that if the people of the State desire and are willing to pay for increased services to the cerebral palsied, the Crippled Children Society will increase its activities and services. The Society is confident that it can raise additional funds as effectively and with as great or greater economy as the UCP.

The final determination of the policy to be followed by the Crippled Children Society will rest primarily in the hands of the doctors throughout the State. Neither organization can operate effectively without the cooperation and help of the Medical Profession. The Crippled Children Society will be guided in a large measure by the advice and counsel of the Medical Profession, speaking through its local and state organizations and in particular through State and local

Medical Advisory Boards of State and County Crippled Children Societies.

Let it be clearly understood that on the part of the Crippled Children Society there is no "professional jealousy" or organizational competition involved in the question of the UCP entering this State and setting up money-raising and service affiliates in the field of cerebral palsy. The money to finance both organizations will come from the people of South Carolina. It, therefore, becomes primarily a question of whether the people of the state desire to finance two organizations serving largely the same needs. If so, the question then becomes one of how the two organizations can work in the same field of service without duplication of effort and services and with a minimum toll against the contributor's dollar for expenses and with maximum benefits to the cerebral palsied in this state.

The doctors are better qualified than anyone else in South Carolina to give the proper answers to these questions. The Crippled Children Society of South Carolina will welcome the guidance of the Medical Profession.

Sincerely,
A. L. M. Wiggins, President
Crippled Children Society
of South Carolina

NEWS

Dr. Jack A. Thurmond recently completed his internship at General Hospital, Greenville, and is now associated in general practice with Dr. A. D. Couch in the McCravy Building on Pendleton St.

Dr. A. W. Lowman, Denmark physician, was installed as president of the Denmark Lions club at the regular meeting of the club on July 8.

Dr. Michael C. Watson, who was graduated in 1952 from the South Carolina Medical College, moved to Bamberg and has established an office on Bridge Street in the building used by the late Dr. T. M. Stuckey.

Dr. Frank F. Espey has opened offices at 123 Mallard St. for the practice of neurosurgery. He is the first specialist in that field to locate in Greenville.

Dr. B. Lewis Barnett of Woodruff discontinued his practice in the Anderson Building on July 22, for an extended tour with the U. S. Navy. He reported for temporary duty at the U. S. Naval Hospital in Charleston on August 2.

Dr. James MacDonald arrived recently to begin practice at Joanna.

Dr. Max A. Culp, native of Edgemoor has opened his office for the general practice of medicine at 132 Confederate St., Fort Mill.

Joanna Memorial Hospital marked its fifth anniversary with more than 125 persons attending a barbecue dinner at Joanna Club House and a tour of the hospital.

The 14-bed hospital facilities include an operating room, X-ray room, laboratory and complete obstetrical department. The hospital, representing an investment of more than \$150,000, was erected as an employee-employer projects by voluntary contributions from Joanna employees and a generous gift from the late William H. Regnery of Chicago.

Norton L. Williams, M. D. has opened an office for the practice of Psychiatry and Psychoanalysis at 164 Wentworth Street, Charleston.

Dr. Rhett Talbert will teach in the neurology department at the Medical College and will also engage in private practice and consultation. He has completed work in neurology at Massachusetts General Hospital in Boston and at Richmond.

Dr. Charles R. Propst has opened an office for the practice of pediatrics in Sumter.

The thriving Joanna Cotton Mills community now has two private practitioners to serve the medical needs of the people of that area.

Dr. James Macdonald recently moved there with his family and began practice on July 15 with his office located on Joanna Square at the entrance of the mill.

Dr. D. H. McFadden, whose residence is on Milton Road, began the practice of medicine at Joanna in 1941.

Dr. James Pierce Horton, Jr., and Dr. William Elford Sims, Jr., have announced the opening of their offices in the building formerly occupied by the Lancaster Telephone Company for the general practice of medicine in Lancaster.

Dr. Emory L. Langdale began the practice of medicine in Walterboro on July 12. He is associated with Dr. Marshall Bennett.

Dr. George Soloyanis became South Carolina's first director of community services with the State Mental Health Commission July 1.

For the past year, he has been clinical psychologist with the Greenville Mental Hygiene Clinic.

Dr. H. LeRoy Brockman, a nephew of Dr. W. Thomas Brockman of Greenville, opened offices for the practice of surgery in Greer about July 1.

Dr. Hugh H. DuBose of 308 Fulton Street has opened an office at 1515 Bull St. where he will practice internal medicine in Columbia.

Dr. C. M. Lide has taken a position with the Veterans Administration and has closed his office in Florence.

Dr. J. Heyward Gibbes has announced the association of Dr. James C. Vardell, Jr. in the practice of internal medicine at 1417 Hampton Street, Columbia, S. C.

Give the United Way!

PRESIDENT'S NOTES

All of you are probably aware of the fact that the Naturopaths have entered suit in the courts asking clarification of the Naturopathy laws of this state. Evidently, the intent is to make legal the prescribing of narcotics by that sect. Our executive secretary, Mr. Meadors, is joining with the Attorney General in answer to the suit and will keep us informed as to the outcome.

Though the legislature is not immediately concerned in this present suit, I believe it would be wise for each of us to let our legislators and senators know something of the character and type of training given to Naturopaths in order that they might be better qualified to pass upon any legislation which should come before them regarding this sect.

TOM GAINES

(Cont'd. from page 272)

COMMITTEE ON RURAL HEALTH:

Dr. W. W. Pressly, Chairman ----- Due West
Dr. C. R. F. Baker ----- Sumter
Dr. Ned Camp ----- Anderson

COMMITTEE ON INDIGENT CARE:

Dr. William S. Brockington, Chairman --- Greenwood
Dr. Henry F. Hall ----- Columbia
Dr. Roderick MacDonald ----- Rock Hill
Mr. M. L. Meadors, ex-officio ----- Florence

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY:

Dr. O. B. Mayer, Chairman ----- Columbia
Dr. George Blalock ----- Clinton
Dr. John Buchanan ----- Winnsboro
Dr. J. A. Siegling ----- Charleston
Dr. Carl West ----- Camden
Mr. M. L. Meadors ----- Florence

MEDICAL ADVISORY BOARD TO THE CRIP- PLED CHILDREN'S SOCIETY OF SOUTH CAROLINA:

Dr. Joseph I. Waring, Chairman ----- Charleston
Dr. William Weston, Jr., Vice-Chairman --- Columbia
Dr. John Bell ----- Greenwood
Dr. C. Guy Castles ----- Columbia
Dr. William R. DeLoach ----- Greenville
Dr. James T. Green ----- Columbia
Dr. Samuel H. Haddock ----- Anderson
Dr. George Dean Johnson ----- Spartanburg
Dr. Joseph H. King ----- Manning
Dr. Frederick E. Kredel ----- Charleston
Dr. Sam G. Lowe, Jr. ----- Rock Hill

Dr. E. Walter Masters ----- Columbia
Dr. Julian P. Price ----- Florence
Dr. John A. Siegling ----- Charleston
Dr. W. O. Whetsell ----- Orangeburg
Dr. Tom Gaines, ex-officio ----- Anderson

COMMITTEE ON CONVENTION CRUISE:

Dr. Harry A. Davis, Jr., Chairman ----- Sumter
Dr. Richard W. Hanckel ----- Charleston
Dr. R. Murdock Walker ----- Sumter

COMMITTEE ON INDUSTRIAL HEALTH:

Dr. W. W. Edwards, Chairman, Surgery -- Greenville
Dr. James L. Hughes, G. P. ----- Greer
Dr. Edward M. Gunn, Occ. Med. ----- Hartsville
Dr. Izard Josey, Int. Med. ----- Columbia
Dr. Frank Stelling, Orthopedics ----- Greenville
Dr. David S. Asbill, Ophthalmology ----- Columbia
Dr. Clay W. Evatt, Otolaryngology ----- Charleston
Dr. J. W. Wyman, Dermatology ----- Anderson
Dr. Katherine MacInnis, Allergy ----- Columbia
Dr. Samuel Fisher, Radiology ----- Greenville
Dr. William P. Beckman, Psychiatry ----- Columbia
Dr. Manley Hutchinson, Gyn. ----- Columbia

COMMITTEE ON MEDICAL EDUCATION:

Dr. John T. Cuttino, Chairman ----- Charleston
Dr. J. Decherd Guess ----- Greenville
Dr. Pierre Jenkins ----- Charleston

COMMITTEE ON THE CARE OF THE PATIENT:

Dr. Walter Mead ----- Florence
Dr. J. K. Webb ----- Greenville
Dr. C. R. May ----- Bennettsville
Dr. W. T. Hendrix ----- Spartanburg
Dr. Henry Robertson ----- Charleston

ANNOUNCEMENTS

SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE

I would like to take this opportunity to extend an invitation to every practicing physician in South Carolina to attend the Sixth Annual Scientific Assembly of the South Carolina Academy of General Practice to be held in Columbia at the Columbia Hotel on September 28 and 29, 1954.

We feel that an excellent program has been arranged; one that will be of interest to all, but of particular value to the general practitioner. It is highlighted by the appearance of Dr. Russel L. Cecil, Professor of Clinical Medicine, Emeritus, Cornell University, New York; as well as Dr. Philip A. Mulherin, Professor of Pediatrics, University of Georgia Medical School, Augusta, Georgia, and many of the outstanding members of the faculty in Charleston.

The program follows:

SIXTH ANNUAL SCIENTIFIC ASSEMBLY OF SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE COLUMBIA HOTEL, COLUMBIA, S. C. September 28 and 29, 1954

PROGRAM

Tuesday, September 28, 1954

- 8:30 a. m. Registration
- 9:20 a. m. Welcome—Dr. David F. Adcock
President Columbia Medical Society
- 9:30 a. m. "Care of the Premature Infant"
Dr. Philip Mulherin
Professor Pediatrics, University of
Georgia Medical School, Augusta,
Georgia
- 10:10 a. m. "Arthritis" Dr. Russel L. Cecil
Professor of Clinical Medicine Emeritus,
Cornell University, New York
- 11:20 a. m. "The Diagnosis of Cervical Carcinoma"
Dr. Lawrence L. Hester, Jr.
Assistant Professor of Obstetrics and
Gynecology, Medical College of South
Carolina, Charleston, S. C.
- 1:00 p. m. Luncheon—
Speaker—Dr. John R. Bender, Winston
Salem, N. C. Vice president Elect,
American Academy of General Prac-
tice
- 3:00 p. m. "Antibiotic Antagonism and Synergism"
Dr. Charlton deSaussure, Department
Medicine, Medical College of South
Carolina, Charleston, S. C.
- 3:50 p. m. Panel Discussion:
"Hemorrhage in Late Pregnancy"
Moderator—Dr. Lawrence L. Hester
Discussants:
Dr. T. G. Herbert, Jr.
Dr. G. F. Wilson
Dr. W. C. Finger
Dr. J. R. Sosnowski
Associate Professors of Obstetrics
and Gynecology, Medical College
of South Carolina, Charleston,
S. C.
- 7:00 p. m. Refreshments
- 8:00 p. m. Banquet—Speaker: Dr. W. B. Hilde-
brand, Menasha, Wisconsin,
President American Academy of Gen-
eral Practice

Wednesday, September 29, 1954

- 8:30 a. m. Registration
- 9:30 a. m. "The Allergic Child"—Dr. Philip Mul-
herin
- 10:20 a. m. "Cortisone and ACTH in Infectious Dis-
eases"
Dr. Charlton deSaussure
- 11:15 a. m. "Gout"—Dr. Russel L. Cecil
- 1:00 p. m. Luncheon—
Speaker: Dr. Thomas R. Gaines,
Anderson, S. C.
President South Carolina Medical
Association
- 2:45 p. m. Round Table Discussion:
Moderator: Dr. John T. Cuttino,
Dean Medical College of South Caro-
lina, Charleston, S. C. Participants: all
visiting lecturers
- 4:00 p. m. Business Meeting
Adjournment

I hope that it will be my pleasure to see many of you in Columbia September 28 and 29.

Sincerely,

W. Wyman King, President

South Carolina Academy of General Practice

CLINICAL FELLOWSHIPS OF THE

AMERICAN CANCER SOCIETY

A limited number of Fellowships offer graduates in medicine opportunities for postgraduate training, emphasizing diagnosis and treatment of cancer.

Fellowships available on and after July 1, 1955 will be awarded for one year and are renewable to and including three years.

Fellowships are awarded to *institutions* only upon applications by deans, executive officers or department heads.

Individuals desiring such Fellowships should consult the appropriate authority in the institution of their choice.

Applications for Fellowships for the year 1955-56 must be submitted prior to September 15, 1954.

Further information may be obtained from:

AMERICAN CANCER SOCIETY
PROFESSIONAL EDUCATION SECTION
47 Beaver Street
New York 4, N. Y.

The South Carolina Chapter of the American College of Surgeons plans a meeting at the Columbia Hotel in Columbia, S. C. on October 29th and 30th. This meeting is not exclusively for the members of the College of Surgeons.

There will be several very outstanding guest speakers such as, Dr. John Adams of Boston; Dr. Bradley Coley, Cancer Authority, Memorial Hospital, New York; Dr. Don Russell, President, University of South Carolina; Dr. William Rienhoff, Johns Hopkins; Dr. Alton Ochsner of New Orleans or others.

Sectional meetings and seminars will be planned in addition to the General Assembly meeting.

There will be a banquet and dance on the evening of October 29. The Scientific Session will terminate Saturday noon in time for all to occupy a special section on the 50-yard line at the Carolina-Maryland football game.

Registration will start early Friday morning, October 29th.

Reservations for football tickets and for the dining room should be made with Dr. John R. Timmons, 1401 Taylor Street, Columbia, S. C.

SOUTH CAROLINA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

A joint meeting of the North Carolina Eye, Ear, Nose, and Throat Society and the South Carolina Society of Ophthalmology and Otolaryngology will be held at Durham, N. C., November 4, 5, and 6, 1954. Headquarters will be the Washington Duke Hotel.

Guest otolaryngologists will be Dr. Stanton A. Friedberg of Chicago, Dr. John Maxwell of Ann Arbor, and Dr. George Bavlin of Durham. The following guest ophthalmologists will likewise be on the program: Dr. Charles Iliff of Baltimore, Dr. John McLean of New York, and Dr. Townlev Paton of New York.

On Wednesday preceding the beginning of the meeting, operative clinics will be held in the various hospitals of Durham and Chapel Hill.

Finally, there will be a football game on Saturday afternoon between the University of North Carolina and the University of South Carolina in Chapel Hill.

The 1954 Annual Convention of the National Society for Crippled Children and Adults will be held Nov. 3-5, 1954, at the Hotel Statler, Boston, Mass.

TENNESSEE VALLEY MEDICAL ASSEMBLY

(Sponsored by the Chattanooga and Hamilton County Medical Society)

**READ HOUSE, CHATTANOOGA,
TENNESSEE
Will Be Held On**

Monday, September 27, and Tuesday, September 28,
1954

Registration fee is \$15, and includes the banquet on Monday night. Early registration is urged and should be sent to Robert C. Hart, Executive Secretary, 108 Medical Arts Building, Chattanooga, Tennessee.

The 37th Annual Conference of the American Occupational Therapy Association will be held at the Shoreham Hotel, Washington, D. C., October 16-22, 1954. The meetings will be as follows:

October 16-17—Preliminary Meetings.

October 18-19—Institute—International Relations.

October 20-21-22—General Conference—Theme:
"Capitalize Your Assets"

INTERNATIONAL ACADEMY OF PROCTOLOGY

1954-1955 AWARD CONTEST

The International Academy of Proctology announces its Annual Cash Prize and Certificate of Merit Award Contest for 1954-1955. The best unpublished contribution on Proctology or allied subjects will be awarded \$100.00 and a Certificate of Merit. Certificates will be awarded also to physicians whose entries are deemed of unusual merit. This competition is open to all physicians in all countries, whether or not affiliated with the International Academy of Proctology. The winning contributions will be selected by a board of impartial judges, and all decisions are final.

The formal award of the First Prize, and a presentation of other Certificates, will be made at the annual Convention Dinner Dance of the International Academy of Proctology, in March 1955. The International Academy of Proctology reserves the exclusive right to publish all contributions in its official publication, "The American Journal of Proctology". All entries are limited to 5,000 words, must be typewritten in English, and submitted in five copies. All entries must be received no later than the first day of February, 1955. Entries should be addressed to the International Academy of Proctology, 43-55 Kissena Boulevard, Flushing, New York.

SOUTHERN MERICAL ASSOCIATION

Forty-Eighth Annual Meeting

Keil Municipal Auditorium

ST. LOUIS, MISSOURI

November 8, 9, 10 and 11, 1954

Registration, Scientific and Technical Exhibits, and
Section Meetings in Keil Municipal Auditorium
All Activities Under One Roof

AMERICAN MEDICAL WRITERS' ASSOCIATION MEETING, CHICAGO, SEPT. 24

The 11th Annual Meeting of the American Medical Writers' Association will be held at the New Hotel Sherman, Chicago, Friday, Sept. 24. This is the Association's first Chicago meeting and an unusual, full day program, comprising 17 speakers, has been arranged. The morning program is a symposium and panel concerning the new 4 year courses of medical journalism and writing to be given at the University of Illinois and University of Missouri.

To increase the number of well-trained teachers in the field of preventive medicine, the National Foundation for Infantile Paralysis is now offering a limited number of senior fellowships to physicians interested in study and research in the teaching of preventive medicine. This is a new effort to bring support to this field.

The program of study may be undertaken at an approved school of public health or in a department of preventive medicine of an approved medical school.

Fellowships will be awarded for one or more years, with stipends ranging from \$4,500 to \$7,000 a year, depending upon marital status and number of dependents.

For further information address the National Foundation for Infantile Paralysis, Division of Professional Education, 120 Broadway, New York 5, N. Y.

AMERICAN COLLEGE OF PHYSICIANS TO USE NATIONWIDE TV CLOSED CIRCUIT TELECAST IN CONNECTION WITH ITS POSTGRADUATE PROGRAM

On Thursday evening, September 23, 1954, from 6:00 P. M. to 7:00 P. M., Eastern Daylight Saving Time, the American College of Physicians will utilize television through a national closed circuit over the Columbia Broadcasting System to carry to its members and their colleagues a SYMPOSIUM ON THE MANAGEMENT OF HYPERTENSION. This telecast is made possible through the co-operation and generous support of Wyeth Incorporated of Philadelphia, and will be the first nationwide closed circuit hookup for postgraduate medical education.

The panel of distinguished physicians who will participate includes:

Cyrus C. Sturgis, M.D., F.A.C.P., Presiding
President, American College of Physicians
Professor of Internal Medicine
University of Michigan, Ann Arbor

F. H. Smirk, M.D., F.R.A.C.P.
Professor of Medicine, University of Otago
Dunedin, New Zealand

Garfield G. Duncan, M.D., F.A.C.P.
Director of the Medical Division
Pennsylvania Hospital, Philadelphia

R. W. Wilkins, M.D., F.A.C.P.
Chief, Hypertension Clinic
Massachusetts Memorial Hospital, Boston
Edward D. Freis, M.D. (Associate)
Adjunct Clinical Professor of Medicine
Georgetown University, Washington

Professor Smirk is one of the topmost authorities of the world on methonium compounds. He went to New Zealand from England in 1940 to take the Chair of Medicine at the University of Otago. He is a Fellow of the Royal College of Physicians of London and of the Royal Australasian College of Physicians, being the Senior Censor for the latter in New Zealand. He appears on this program as an official representative of the Royal Australasian College of Physicians in connection with an exchange-guest program being arranged between the two Colleges.

A "closed TV circuit" is one by which reception is controlled and not open to the general TV public. This telecast cannot be picked up in the home, but the invited audience must go to the TV receiving station. Twenty-three such receiving stations will be used; these will be located in Boston, New York, Philadelphia, Washington, Pittsburgh, Charlotte,

Atlanta, Cincinnati, Detroit, Chicago, St. Louis, Milwaukee, Minneapolis, Memphis, Dallas, Houston, New Orleans, Denver, Salt Lake City, Los Angeles, San Francisco, Baltimore and Cleveland.

DEATHS

DR. J. P. STUKES, SR.

Dr. J. P. Stukes, Sr., 77, member of an old South Carolina family noted for its doctors and judges, died at his home at Macon, Ga., July 4.

DR. D. T. TEAL

Dr. D. T. Teal, 83, senior physician of Chesterfield County, died at his home July 29 after completing 60 years active practice of medicine.

SOUTH CAROLINIANA

Abstracts by Dr. Manly Stallworth

Prioleau, Wm. H., Stallworth, J. M.

Gaseous Distention of the Gastrointestinal Tract — Its Significance, Prevention and Treatment. (American Surgeon 19:418, May 1953)

Gaseous distention of the G.I. tract should be prevented if possible and when present, every effort should be directed toward its relief. Swallowed and ingested air is the predominant factor in bowel distention. This can be prevented and treated by suction intubation of the stomach and intestines, and by enterostomy. Enemas and drugs are of little value and at times harmful. Compromise of the blood supply must not be overlooked.

Prioleau, Wm. H., Stallworth, J. M.

The Supportive Boot for Chronic Venostasis. (G.P. 9:47, March 1954).

A suitable and adequate support to the venous return is essential to the satisfactory treatment of most cases of chronic venostasis. It is of value as a diagnostic measure, in preparing the patient for operation, and for long continued palliation. A combination of Unna's paste and elastic adhesive has proven satisfactory in most cases. The pulsatile air-pressure boot is particularly suitable for long continued use.

Wallace, F. T., Wilson, R. S., Thompson, W., (Spartanburg)

Prolapse of the rectum in children. (Tri-State Med. j. 1:11-12, Sept. 1953).

A method of direct linear cauterization to the rectum extending from the ano-rectal junction for about 3 inches proximally into the rectum, performed to promote scarring and fixation in an effort to prevent recurrent prolapse of the rectum in children, is presented. The authors reported no permanent recurrences of the prolapse of the rectum.

Webb, J. K. (Greenville)

Adrenalectomy in recurrent breast cancer. (Tri-state med. j. 1:12-14, Sept. 1953).

The case of a 65 year old woman who had recurrent metastatic carcinoma following breast amputation and irradiation, done 18 months previous-

ly is presented. Additional x-ray and testosterone gave only temporary improvement. Bilateral adrenalectomy and oophorectomy resulted in regression of the size of the metastatic lesion, and a sense of well being in the patient.

Parker, E. F. (Charleston)

The early diagnosis of carcinoma of the esophagus. (Am. Surgeon 20:424-434, April 1954).

In order to ascertain the reasons for delayed diagnosis, the author reviewed the records of 187 cases of epidermoid carcinoma of the esophagus. He lists the commonly associated symptoms, the causes for erroneous diagnoses, and emphasizes these points, utilizing case histories. The value of esophagograms in the absence of fluoroscopic finding, and repeated esophagoscopy examinations are stressed in the study of patients with possible carcinoma.

Wilson, R. S., Wallace, F. T., Whiting, J. A. & Poole, C. H. (Spartanburg)

Technical aid in esophageal diverticulectomy. (J. of intern. college surg. 20:192-195, August 1953).

A case study is presented of a 55 year old woman with an esophageal diverticulum, which was treated by one stage excision utilizing a flexible Cameron type of light inserted into the pouch by the transoral route in order to visualize the diverticulum during the operative excision. The wound healed uneventfully and the patient was discharged from the hospital 14 days after operation, without symptoms.

Corbett, W. M. & Fellers, F. H. (Columbia)

Traumatic liver abscess. (Tri-state M. J. 1:11-12, Jan. 1954).

After a review of the incidence, pathology, symptoms, prognosis, and treatment of trauma to the liver and secondary abscesses, the authors present the case of a 34 year old man who sustained a blow to the upper abdomen followed by the formation of a sterile abscess which was drained anteriorly about 5 weeks after the accident, resulting in complete recovery of the patient.

Dramamine's® Effect in Vertigo

Dramamine has become accepted in the control of a variety of clinical conditions characterized by vertigo and is recognized as a standard for the management of motion sickness.

Vertigo, according to Swartout, is primarily due* to a disturbance of those organs of the body that are responsible for body balance. When the posture of the head is changed, the gelatinous substance in the semi-circular canals begins to flow. This flow initiates neural impulses which are transmitted to the vestibular nuclei. From this point impulses are sent to different parts of the body to cause the symptom complex of vertigo.

Some impulses reach the eye muscles and cause nystagmus; some reach the cerebellum and skeletal muscles and righting of the head results; others activate the emetic center to result in nausea, while still others reach the cerebrum making the person aware of his disturbed equilibrium. *Vertigo may be caused by a disease or abnormal stimuli of any of these tissues involved in the transmission of the vertigo impulse, including the cerebellum and the end organs.*

A possible explanation of Dramamine's action is that it depresses the overstimulated labyrinthine structure of the inner ear. Depression, therefore, takes place at the point at which these impulses, causing vertigo, nausea and similar disturbances, originate. Some investigators have suggested that Dramamine may have an additional sedative effect on the central nervous system.

Repeated clinical studies have established Dramamine as valuable in the control of the symptoms of Ménière's syndrome, the nausea and vomiting of pregnancy, radiation sickness, hypertension vertigo, the vertigo of fenestration procedures, labyrinthitis and vestibular dysfunction associated with antibiotic therapy, as well as in motion sickness.

Any of these conditions in which Dramamine is effective may be classed as "disease or abnormal stimuli"* of the tissues including the end organs (gastrointestinal tract, eyes) and their nerve pathways to the labyrinth.

Dramamine (brand of dimenhydrinate) is supplied in tablets of 50 mg. and liquid (12.5 mg. in each 4 cc.). It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.



The site of Dramamine's action is probably in the labyrinthine structure.

*Swartout, R., III, and Gunther, K.: "Dizziness:" Vertigo and Syncope. GP 8:35 (Nov.) 1953.

BOOK REVIEW

EMERGENCY TREATMENT AND MANAGEMENT, by Thos Flint, Jr. W. B. Saunders, Philadelphia, 1954. Price \$5.75.

This book is written for the "Emergency Physician," whether he functions in a hospital emergency room or in his own office. It contains a lengthy and detailed compilation of the innumerable conditions which may suddenly and imperatively confront any practitioner. In this respect it should be as valuable as it is inclusive. Its cross references are handy and its presentations are complete but succinct. In reviewing a book such as this the temptation to sample the items with which one is more likely to be familiar is irresistible. Thus opinion may differ or carry a certain

bias. Be that as it may we must necessarily lift an eyebrow at a number of minor points, such as the definite admonition to limit barbiturate prescriptions to only a few doses, the unmodified recommendation of arbitrary fractional doses for children, the use of trade names for official drugs. We wonder why simple blepharitis and conjunctivitis must be referred to an ophthalmologist, and why the capable physician of the emergency room should not be fit to open a bulging eardrum (surely a pediatric emergency). Why saline solution for acidosis when others might be better? Why speak of the drastic results of ingestion of kerosene when aspiration is the important factor? And why use Brown Mixture, and worse, why call it "Brown's Mixture"?

But all of these are relatively minor matters, and if the reader differs in details, he can make his own corrections. As an "Emergency Physician", he would be glad to have this book nearby.

J. I. W.

AT THIS VERY MOMENT

At this very moment more than two million men and women, and boys and girls too, are mobilizing all over the nation for this year's greatest voluntary fund raising effort.

Working together to provide operating funds for almost 20,000 health, recreation, family welfare and defense related services, these volunteers must raise \$290,000,000 . . . the millions of dollars needed to help keep millions of people healthy in mind, in body and in spirit.

When your community volunteer calls on you for your once-a-year contribution to your town's Community Chest, United Fund or Red Feather campaign, he brings you an opportunity to give your support to many appeals at one time.

Remember to give generously . . . the united way.



Give the United Way!

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904
ASHEVILLE, NORTH CAROLINA



Affiliated with Duke University.

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

The Hospital is located in a 75 acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. Charman Carroll, M.D., Diplomate in Psychiatry. — Medical Director.

Robt. L. Craig, M. D., Diplomate in Neurology & Psychiatry, Associate Medical Director.



BURDICK ULTRAVIOLET LAMP

WE CAN EQUIP YOUR OFFICE COMPLETE—

CONSULTATION ROOM FURNITURE
EXAMINING & TREATMENT
SHORT WAVE DIATHERMY
SCIENTIFIC EQUIPMENT
DIAGNOSTIC EQUIPMENT
LABORATORY SUPPLIES
SURGICAL INSTRUMENTS
FRACTURE EQUIPMENT
GENERAL SUPPLIES

DISTRIBUTOR OF KNOWN BRANDS OF PROVEN QUALITY

We **SERVICE** what we **SELL**



W i n c h e s t e r

CAROLINAS HOUSE OF SERVICE



Winchester Surgical Supply Co.
119 East 7th St. Tel. 2-4109 Charlotte, N.C.

Winchester-Ritch Surgical Co.
421 W. Smith St. Tel. 5656 Greensboro, N.C.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

SOUTHERN MEDICAL AUXILIARY WHAT IS THE SOUTHERN AUXILIARY AND WHY WAS IT ORGANIZED?

The Southern Medical Auxiliary is comprised of the wives of doctors who are members of the Southern Medical Association. There are no dues in the auxiliary; wives automatically become members of the auxiliary when their husbands join the Association whose dues are \$10.00 per year which includes the very wonderful Southern Medical Journal published monthly; and there is NO REGISTRATION FEE AT CONVENTION. The Association was organized in 1906 in Chattanooga, Tennessee, for the primary purpose of studying more intimately the problems of Southern medicine and diseases peculiar to the southern states, the results of this research and clinical experience to be shared with the world. It is the second largest general medical association in the country and now in its 48th year.

The Woman's Auxiliary to the Southern Medical Association was organized in New Orleans, La., November 25, 1924 by a group of wives who attended the meeting with their husbands, for the purpose of promoting friendliness and good fellowship among physicians and their families. The Association each year appropriates sufficient money for our expenses.

WHAT IS THE JANE TODD CRAWFORD MEMORIAL STUDENT LOAN FUND?

This fund was created in 1928 to honor the memory of that courageous Kentucky pioneer woman who submitted to the first ovarian operation without benefit of anesthesia, which was performed by Dr. Ephraim McDowell in Danville, Ky., on Christmas Day, 1809. This fund is voluntarily contributed to by counties in the Southern States, which money is loaned at 3% interest rate to any student or doctor who can qualify to further his knowledge in the study of gynecology.

WHAT IS RESEARCH AND ROMANCE OF MEDICINE?

This project was adopted in 1930 to preserve the medical history of the south with biographies of doc-

tors; histories of medical societies and auxiliaries and their projects; nurses and others who have contributed to the progress of medicine.

WHY IS DOCTOR'S DAY CELEBRATED?

In 1935, March 30th was designated as "DOCTOR'S DAY" by the Southern Auxiliary to honor members of the medical profession both living and dead, this date being selected because in 1942 Dr. Crawford Long of Georgia first successfully used anesthesia. In 1949 the red carnation was adopted as the official flower for Doctor's Day, and all Southern States observe the day in various ways.

ANNUAL CONVENTION

The Annual convention of the Woman's Auxiliary to the Southern Medical Association will be held in conjunction with the meeting of the Association in St. Louis, Missouri, Nov. 8-11, 1954. All Doctors and their wives in South Carolina are cordially invited to attend.

Mrs. Kirby D. Shealy
Councillor for South Carolina

MRS. ALFRED F. BURNSIDE ELECTED NATIONAL DIRECTOR

The Auxiliary to the South Carolina Medical Association is honored to have Mrs. Alfred F. Burnside of Columbia elected to the Board of Directors of the Auxiliary to the American Medical Association. Roberta has been a prominent figure in Auxiliary activities. She has served her local auxiliary in varied capacities, served as president of the Auxiliary to the South Carolina Medical Association, as program chairman of the national auxiliary and as a member last year of the nominating committee of the Auxiliary to the A. M. A. During the past year she served as Doctor's Day Chairman of the Auxiliary to the Southern Medical Association and is currently First Vice-President of the Southern Auxiliary. All this recognition has been justly deserved and to her new high position Roberta takes a wealth of experience in leadership and service in medical auxiliary work.

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.



The Journal

of the

South Carolina Medical Association

VOLUME L

October, 1954

NUMBER 10

Treatment of Neuroses in General Practice

BALDWIN L. KEYES, M. D.

Philadelphia, Pennsylvania

Scientific methods of treatment for neuroses have developed steadily since the first world war and have received a fresh stimulus since the second world war, particularly in the direction of more rapid techniques for more rapid rehabilitation.

Through this period there has been a gradual tendency to set aside older, though still usable, treatment systems and rely almost wholly on analytic procedures for the care of these patients.

While it is generally agreed that a formal psychoanalysis is probably the most satisfactory method of reaching for and correcting the fundamental causes of neuroses, nevertheless, the very formality, rigidity and time factor of this procedure renders it unavailable to most of those requiring it.

It has become necessary, therefore, to develop more practical methods of treatment which can be made available to the average patient wherever he is.

For these reasons, although most psychiatrists tend to follow certain fundamental principles in their understanding and interpretation of neurotic symptoms and emotional manifestations, there is a decided difference in the methods of approach in the management of patients and in psychotherapeutic procedures. An enormous number of psychoneurotic patients have to depend entirely upon the care of physicians in general practice who, by and large, have been carrying these patients along in an increasingly more satisfactory manner.

Psychiatrists seem to cling to the larger cities so that they are not generally available in many of the smaller towns, and are par-

ticularly inaccessible to the rural districts in most areas.

The custom is increasing therefore, for the rural general practitioner to send his patient to the nearest city psychiatrist from whom he then properly expects a complete diagnostic survey, an evaluation and explanation of the neurosis, a practical plan for management, and suggestions for psychotherapeutic procedures, sufficiently practical to allow the family doctor to continue adequate care of the patient, with an occasional revisit to the psychiatrist for follow-up and further suggestions.

This would obviously require that the family doctor have a working knowledge of the major psychopathologic entities and the ability to understand and deal with people. Further it is essential that the psychiatrist be thoroughly practical in the recognition of the difficulties which arise in the handling of such a patient in a busy general practice where the time factor alone presents an important problem.

In discussing any method of treatment for the handling of nervous patients it may be well to keep in mind that all does not depend alone on psychotherapy, and that psychotherapy is not limited only to the interpretation of psychopathology.

The first recognized psychiatrist, Imhotep, the Egyptian about 4000 B. C., recommended, for those patients who were in distress of mind or soul, that they be taken to quiet watering places to have baths, soothing massage, quiet music and peacefulness around them.

Down through the ages this principle of controlling the environment to lessen stress

for the nervous patient has been followed.

Through the monumental work of Freud and his followers in revealing mental mechanisms and psychopathology, interest more recently has been very largely directed toward an attempt to understand the dynamics, the motivation and the conflict situation of the neuroses.

Therefore, treatment in psychiatry in recent years has been directed toward the uncovering of instinctual urges, to the recognition of specific failures in adaptation, to the unraveling of conflict situations and to helping the patient to understand the meaning of his symptoms, and to tolerate and control his emotional problems.

Briefly a few of the principal motivations which drive all of us forward are (1) an effort to attain mastery over ourselves, (2) to attain social approval, (3) to possess security, and (4) to acquire a satisfying love and all that that implies.

Actually full normalcy means a complete acceptance of all dynamic drives, the possession of adequacy to withstand stress in all spheres, and the ability to function as an asset to one's group.

A failure in any direction means frustration, which, if well controlled, indicates satisfactory adjustment; though if uncontrolled, means maladjustment. To use simple terms, then, maladjustment means unsatisfactory controlled frustration. Thus we are presented immediately with a point of attack for treatment even though we may not have an opportunity to go further in our investigation to determine the origin of the frustration and the reasons they are uncontrolled.

Treatment must include then, adequate training in the control of responses to a frustration which cannot be altered.

Where it is possible we attempt to go behind the curtain of inhibition and defense in an effort to determine the nature of the frustration, and further to define and clarify the conflict situation behind that, and to understand the dynamic forces at play with their specific emotional distortions. Through cautious interpretation of the meaning of symptoms and careful re-education, we may be able to relieve our patients of some of their emo-

tional turmoil and frustration, and to render them more adequate to accept comfortably their own self control.

Our objective is correction of maladjustment and development of personality adequacy. Any outline of psychotherapy therefore involves teaching the patient to understand his situation within himself, the nature of his illness, and his weaknesses. He would have to learn his limitations and make adjustments to them. He would have to learn what dormant abilities he may have and to develop them for an aid in furthering self-confidence. The patient must be taught to develop control of himself. He must be taught to dominate his emotional crises and to react with intelligence, and eventually to develop sagacity in the handling of his personal problems.

We must recognize in many patients with neuroses an etiological predisposition of lower resistance, and a hypersensitiveness to stress in a person who easily develops self-protective avoidance reactions. The maladaptations then are the result of faulty habit reactions and a failure to accept control as a normal experience in handling within oneself sex urges, separations from parents, the hazards of adolescence and responsibility and obligation of adult life; all of which means normal discipline. Patients therefore who are unable to face undue stress are unconsciously seeking escape by some substitute or compromise reaction which we call a psychoneurosis. Such patients are filled with anxiety and are in a state of fear toward their symptoms, their environment and their future, and, by reason of many failures to obtain relief, are apprehensive and doubtful that any help may be given them.

The technique of treatment of a psychoneurotic person requires careful, detailed study of the individual case, and must be undertaken with the spirit of warm, friendly interest and the establishing of the confidence of the patient in the physician. It is well to allow the patient to "talk himself out", to tell his story in his own words, and later to elicit from him a detailed history as to his heredity, his illnesses, his education, career, family life, financial stability, and so forth. Having these facts arranged in chronological order, not only

helps the physician in his estimate of the patient, but establishes further a certainty in the mind of the patient that the physician understands all of his problems and all of the factors in his background. Next a detailed history of the neurosis itself is obtained, in which all of the present symptoms are noted, and an attempt should be made to determine the time of onset of these symptoms as nearly as the patient can trace it. Also there must be obtained an account of the circumstances and the causes of the illness as the patient believes them to exist.

A complete physical and neurological examination with indicated laboratory procedures is most essential, not only to uncover somatic disability and dysfunction, but in furthering the complete perspective of the patient in the mind of the physician, and also in building further confidence in the mind of the patient in his physician. All physical disabilities uncovered must be expertly treated and controlled to give the patient the best possible opportunity to get well.

During the taking of the history and the making of these examinations the physician has been reaching a careful psychiatric evaluation of the patient.

Immediately after the first complete survey of the patient has been made, the physician should have a frank talk with him, explaining directly and in simple terms the significance of all the findings in the case, correlating the various factors, and terminating his discussion by outlining what is to be done in the way of constructive treatment.

In the busy doctor's office a thorough investigation on the first visit certainly is not usually convenient or practical, and it is often necessary to plan specific appointments to complete these examinations before formulating a fixed plan. Where possible such appointments should be carried out within the next two or three days, and brought to a prompt conclusion, for delays are frustrating and destroy confidence.

The doctor's talk to the patient must be positive as well as frank, and his advice and decisions must be on a personal, practical and sensible basis. Obviously such talks must be phrased in the manner suitable to the ability

of the patient to understand and accept them. It is always well to emphasize to the patient the doctor's understanding of the genuineness of his complaint and an appreciation of the fact that he is really suffering; always being careful not in any way to belittle him, or make him feel inferior, but to protect his pride so that he will sense as the result of the discussion that something has been added to his personal dignity.

In order to devote the required amount of time to such a patient many general practitioners have found it expedient to assign certain hours each week by appointment for these patients, and to charge them additionally for the time consumed. The members of some county medical societies have drawn up agreements among themselves for the establishment of some uniformity for such a custom.

Since time is always a factor in the handling of a neurosis, it is frequently quite practical to allow patients to do a certain amount of home work, to help them to uncover some of the outstanding factors in their history.

Most patients rather readily accept the suggestion of writing out an autobiographical sketch, particularly if it is made simple and in outline form, and if it follows planned assignments to be discussed by appointment. It seems easiest for most people to recall their histories in chapters based on pre-school, primary and grammar grades, high school, college, career and so forth. To prevent a long bulky essay it may be well to suggest that they just make headline entries of good and bad experiences. It is sometimes surprising to discover the amount of material some patients can recall and bring forward about significant experiences which they had long ago forgotten.

The accomplishment of an autobiographical sketch in regular sequence can be considered part of his treatment program and becomes important to the patient. He is told specifically to assign himself to a half hour a day for this task, such as a half hour immediately before retiring, when he is to sit quietly alone and let ideas slide through his mind and then jot them down.

Such an outline furnishes a guide for full discussions which may bring forward much

material significant to the physician in his effort to help the patient understand himself. Caution should be exercised not to interpret the material too quickly, but to keep a record of certain items for consideration in the all-over evaluation of the problem, and perhaps later use some of this information in an effort to help the patient develop an insight into the beginnings of his neurosis. Gradually, as his confidence increases, he will learn to make many of his own evaluations, and with the guidance of his understanding physician, will come to recognize why it was necessary for him to have neurotic symptoms, what they meant, and to discover that he no longer needs them.

Later when the autobiographical sketch is fairly complete it may be possible to turn the patient's interest back into determining, through the various phases of his life, those things about which he developed hatreds. It may be possible to get him to discuss many of his accumulated hatreds and loves in the past years without becoming too involved.

It is quite important to recognize in certain disclosures made by the patient some deep-seated emotional conflict situations, which the physician himself may not be able to interpret, but which he can note and lay aside as one of the factors to be discussed later with the psychiatrist who is collaborating with him in the handling of the patient.

While an effort is continually being made for the patient to understand his problems and to learn new ways of handling himself, the doctor must be cautious not to cause confusion by moving forward too rapidly in any re-educational program. All patients will require repeated re-assurance, encouragement and an opportunity to express themselves freely as to their emotions, their doubts, their fears without risk of censorship, so that they may gradually discuss matters of serious moment with less and less sense of guilt, anxiety and emotional turmoil.

Frequently it will be noticed by the attending physician that his patient will approach a subject for discussion only to veer cautiously away from it, because the discussion of that particular subject may be too distressing to him emotionally. It may be well to quietly

make note of such matters so that at future interviews they may be cautiously presented for further discussion.

Many patients will have a block of natural defensiveness and inhibition which will prevent them from discussing emotional problems which they may be barely able to recognize in themselves, or which may be kept out of conscious mind because of the nature of the threat which they carry.

Many past experiences of considerable significance in the clarifying of a neurosis may thus remain buried.

To relieve such situations it has been found expedient to use sedatives such as amytal and pentothal intravenously, slowly administered, to gently induce a less than full conscious state and yet maintain sufficient wakefulness that an outpouring of previously blocked off emotionally disturbing material may be freely expressed.

If carefully managed a lot of valuable historical material can be obtained in this manner for careful future discussion and explanation.

Frequently it is possible to review the same situation in later sessions under less and less sedation until the patient can begin to discuss these subjects consciously and with less and less emotional impact.

Occasionally reliving, with understanding and confidence, a previously blocked-off threatening experience, that is abreacting it, will be tremendously relieving emotionally and may be the turning point in recovery from the neurosis.

Some patients who manifest resistance to talking out may be aided by using twenty mgm. of methedrine with three and three-quarters grains of amytal, for methedrine activates and speeds up cerebration and renders talkative many who have very little verbal ability.

Caution to avoid over-dosage and excessively prolonged stimulation is of course necessary.

The doctor must understand that there are times when the patient will develop emotional feelings toward his doctor, sometimes for and sometimes against him as an inevitable part of any self-exploration. Under such circum-

stances the doctor must be objective and direct the patient into an understanding of the reason for these feelings. Many patients will gain security by developing some dependency upon the physician for a time which will be necessary to them. As the opportunity arises it will gradually be possible to develop in the patient enough self-assurance that this dependency upon the doctor or anyone else becomes less and less a necessity.

In the handling of a neurosis it is necessary to keep in mind the strengthening of the ego, that is to say, the strengthening of the directing or controlling portion of the personality of the patient, for it is the failure in his ability to be able to direct himself in the presence of conflict situations that permits him to have a neurosis.

The doctor's effort therefore, is not only to understand the patient and to have him understand himself, but to teach him new habits of adjustment which would in turn develop this personality strength. Management of the patient through this training program must be thoroughly realistic. He has to learn to develop a tolerance to fatigue, to stress, to adversity, to depression, to anxiety. Through the doctor's re-assurance and his own re-education he gradually learns to accept many of these manifestations of his illness which will fade away gradually as he gains inner strength. New qualities, new aptitudes must be found to capitalize upon with which to develop greater confidence in himself. He can learn to dominate his emotions rather than allowing them to dominate him. He can learn to be intelligent rather than emotional in his decisions and to devise new ways of meeting problems. In other words, any treatment program would involve the unlearning of bad habits of meeting problems and the learning of good habits of meeting those same problems.

In the treatment of any neurosis the members of the immediate family of the patient must come into consideration and not infrequently will require some education in the direction of tolerance of the patient and his symptoms and an understanding of what the patient and the doctor are trying to accomplish so that full cooperation may be attained.

Throughout a therapeutic program a defin-

ite sequence must be adhered to and followed persistently, though with reasonable elasticity. If the doctor does not keep notes, does not follow a sequence for orientation from interview to interview, the patient soon will feel confused and disorganized. A therapeutic program is a teaching schedule and should be arranged to proceed steadily ahead from visit to visit so that the patient, but particularly the doctor, has a plan to guide him throughout treatment.

Most patients should be treated on a work basis, that is to say, at home and on the job, rather than in a sanatorium. The usual patient suffering from a severe neurosis may require a few days in the hospital for a complete study. Those with profound exhaustion and other serious somatic manifestations may require the isolation, rest and security of sanatorium care. Patients who are sufficiently ill to require sanatorium care are so usually because the stress at home and in the office is too great, so that little good will accrue from sanatorium treatment unless complete isolation is insisted upon. To obtain isolation and rest the elimination of visitors and the telephones are essential.

In every case a gradual effort must be made to re-establish the patient in some activity and useful work to maintain specific contact with reality and to aid him to again fit into a social group.

Occasionally a few days under modified narcosis, with hypnotics carefully controlled, is very comfortable to anxious, tense, nervous persons and allows them to get off to a good relaxing start.

Under a routine regime of rest, most patients will readily gain weight. Those who do not and in whom this seems particularly indicated, may be helped considerably by the use of small doses of regular insulin, 15 or 20 units injected intramuscularly, a half hour before each meal. Mild signs of hyperinsulinism may occur, but are usually not very disturbing and are readily alleviated by the use of a lump of sugar or fruit juice. The patient should be supplied with orange or grape juice as a convenient and freely used beverage, off and on all day, and told to carry a few lumps of sugar. Occasionally an eggnog as a regularly

timed diet between meals is very helpful.

A direct effort must be made to build up good muscle tone, at first by means of massage and then gradually increasing exercises. Rest periods after massage, after exercise and after lunch should be insisted upon, preferably in the open air.

Insomnia may be controlled by the use of sedatives, but these tend to be depressing if long continued. It is well to determine the amount of sedation needed and to give it in divided doses such as 7 p. m., 9 p. m. and 11 p. m. The dosage should be enough to insure a full night's rest, and thus avoid the need for medication during waking hours in the early morning period, since patients readily develop the habit of waking for medication at that time and can as easily acquire the habit of sleeping through the night.

Occupational therapeutic measures which are suitable to the specific patient are extremely helpful in re-establishing the ability for concentration and interest, and in resting highly tense nervous patients through the use of their hands, while aiding them to mix with a group on a common level of activity.

All decisions as to rate of progress, amount of work, type and degree of exercise and all other activities are the responsibility of the physician who must have complete disciplinary control at all times. It is extremely important that nurses in charge of such cases understand distinctly the relationship of the authority of the physician to the patient, and also that the nurse be capable of maintaining a friendly control of the situation surrounding the patient.

The gradual development of tolerance to fatigue requires accuracy and caution, so that the advances made are regular and not dependent upon the desire of the patient, and the confidence of the patient in his progress must not be upset by too much enthusiasm in forcing him beyond his actual ability to withstand fatigue.

Medication in the handling of neuroses is largely symptomatic, although it is popular to give vitamins in massive doses, and tonic prescriptions of various kinds are sometimes helpful, such as *nux vomica* in exhausted cases. For those who are particularly anxious and tense,

and show many autonomic nervous system signs, a prescription containing gynergen, belladonna and phenobarbital has proved very comforting.

When simple depression is a prominent symptom in the course of a neurosis, it will often be found quite helpful to administer dextro-amphetamine sulphate either as a tablet or as a "spansule." The dosage may have to be reduced or increased according to the reaction upon the patient. This therapeutic adjuvant has the ability to lessen the depth of a depression and in overdoses may even produce a mild euphoria and pronounced insomnia. Therefore, dexedrine should always be administered during the morning hours. In tense, anxious states, dexedrine not infrequently adds to the discomfort of the patient, causing restlessness and agitation instead of elation and must therefore be used with judgment.

The danger of dependency upon medication of any form is present in the apprehensive neurotic patient who is looking for supports to lean upon, so that frequent changes in prescriptions would seem advisable. Many patients who have long suffered from neuroses have been taking one or another form of bromide or barbiturates to the degree of addiction and are found to be suffering from low-grade chronic bromide or barbiturate poisoning.

Infrequently there will occur patients with neuroses who have an accompanying deep reactive depression of such severity that all usual methods of treatment are impractical and the depression itself must be controlled.

Electro-sleep treatments are helpful at such times though always administered under deep sedation to lessen the patient's awareness to the procedure and to minimize the convulsive reaction. Four or six such treatments are usually enough to control the situation and permit usual psychotherapeutic procedures to be continued.

Rarely one finds a patient with a chronic intractable deep-seated neurosis, usually obsessive compulsive in type, who is completely inviolated and in whom all usual methods, even electro-sleep, have failed to relieve to any degree. Such a patient may be entitled to

the relief occasionally obtained through thermal lobotomy. This procedure is simple and safe in expert hands and has the great advantage of accurate surgical control so that dosage can be measured and repeated easily as required. In some seemingly hopeless cases considerable relief from tension, anxiety and depression has been attained and rehabilitation made possible by this method. These are exceptionally rare cases and must be carefully selected and these procedures considered with great caution.

For the treatment of the psychoneuroses there have been elaborated many psychotherapeutic procedures some of which tend to deviate at tangents involving complicated psychological concepts and overlooking the patient as a whole. It is well to keep in mind that every part of the program planned for the treatment of the patient has some specific psychotherapeutic value as it contributes to the confidence, the understanding and the recoverability of that patient. Every contact with the physician, every change in routine, every alteration in medication may be considered also as having a psychological significance and therefore has psychotherapeutic value.

Whatever form of psychotherapy is attempted will be definitely colored by the personality of the physician, his understanding of the patient, and his ability to develop complete confidence of the patient in him as a physician, and to counsel with and to direct the recovery of this particular patient. The personality and training of the physician frequently determines the method in which he is most successful. One physician will be dominating and aggressive, while another will be re-assuring and persuasive, but in any case positiveness is most essential that the physician may direct the patient's tendencies, and teach him to recognize the struggle he is making between his desires and his wish to attain an average existence in a cultural environment, until he gradually begins to recognize in himself an individual personality in which he can develop pride, and so reach toward a better level of adequacy.

The principles involved in the psychotherapeutic procedure may be summarized

therefore as follows: first, the development of complete confidence and respect by the patient in his physician; second, an opportunity to talk out his problems in detail; third, the patient must learn to face his avoidance reactions by careful explanation of them and the assimilation of advice and suggestions of the physician; fourth, gradually develop insight into his difficulties; he must learn to understand the meaning of his symptoms; fifth, he must develop new mental habits for meeting his problems, which will involve adjustment to his social environment, a recognition of all of his good qualities, a recognition and ability to utilize those qualities which he possesses which will give him power over himself and his situation, and a learning to accept again responsibilities on an active level.

In any discussion of treatment of a neurosis, the question of prevention must be considered and here the importance of the methods of mental hygiene must be emphasized, particularly as applied to early childhood and adolescence. The interest in this subject in parent-teacher groups and in various organizations throughout the country is most encouraging and it is definitely helping to prevent psychoneuroses in adults. A formal psychoanalysis should never be attempted except by an expert in this field, and then only on a very limited group of specially selected patients. A careful follow-up program for every patient with a psychoneurosis is necessary for at least a year or two, for he will be facing problems, both old and new, which he seems almost able to combat, but cannot quite do so. He needs the additional assistance of his physician to carry him along until his tendency to avoid problems is completely overcome and he is again meeting and handling all of his difficulties adequately, with complete self-assurance and mastery over his situation.

The management of neuroses therefore becomes the duty of every physician, particularly of the physician in general practice, who has the greatest opportunity to help the patient in the incipency of his neurosis.

It may be well to keep in mind that any ill patient from whatever cause, is facing the result of fear of his illness, whether conscious or not, as well as the necessity for adjustment to

a new and strange situation, with the threat of not only physical and mental but also economic insecurity. Any physician, wherever he may be practicing, is definitely more helpful to his patient when he demonstrates some understanding of the psychological factors involved during a physical illness.

Every thoughtful physician can readily acquire the art of seeing through the eyes of his patient the specter of disability, even if temporary, and the emotional consequences reacting through the patient and members of his family. Some of these, often barely noticed factors, may influence the nature and duration

of the illness very materially and can be tremendously relieved by a physician who takes time to understand.

BIBLIOGRAPHY

1. Weiss, E.: Modern Attitudes in Psychiatry, Columbia Univ. Press, 1946.
2. Lewis, N.: The Am. J. Psychiat., January 1948.
3. Hamilton, D. M.: Quart. Rev. Psychia. and Neurol., January, 1948.
4. Ebaugh, F. G.: Evaluation of Interviewing Techniques and Principles of Psychotherapy for the General Practitioner, J. Omaha Mid-West Soc., January, 1948.
5. Keyes, B. L.: Treatment in General Medicine (Reimann), F. A. Davis Co., 1939.
6. Jaeger, R.: Personal Communication.

The Diagnosis and Treatment of Meniere's Disease

THEO. E. WALSH, M. D.

St. Louis, Missouri

It is unfortunate that the Diagnosis "Meniere's Disease" is made in many cases of dizziness without proper regard to the triad described by Meniere. The diagnosis should be retained for the condition characterized by nerve deafness, tinnitus and vertigo; the pathological change in which has been shown to be a hydrops of the endolymphatic labyrinth.

Meniere's Disease (endolymphatic hydrops) is primarily a cochlear disease. A careful history will reveal that the disturbance of hearing is present usually a long time before the disabling symptom of vertigo appears. The patient usually presents himself complaining of vertiginous attacks with an accompanying tinnitus; the history of deafness has to be elicited.

VERTIGO

This is a true aural vertigo. The patient states that the vertigo may come on suddenly at any time. Frequently it will occur when he is in bed. There is a sensation of objects moving in a rotary fashion or sometimes he complains that he himself seems to be spinning. The vertigo is usually accompanied by nausea

and vomiting and is incapacitating. It may last for a few minutes or for several days. The attacks may occur fairly regularly at two weekly or monthly intervals or occur frequently and at irregular intervals. There may be long periods of freedom from attack.

TINNITUS

The tinnitus is usually of two kinds (a) a roaring sound likened by some to the sound heard on holding a sea shell to the ear. It may be described as "the sound of surf on the sea-shore" or "of a wind in the forest" and (b), an intermittent and much less bothersome high pitched ringing. The constant roaring tinnitus is the more troublesome of the two. In many instances the tinnitus either disappears just preceding a vertiginous attack or may become very much louder temporarily and be followed by the vertiginous attack.

DEAFNESS

The patient notices a loss of hearing in the affected ear. He usually can state that although he hears sounds, the sounds are distorted and they sound different in the two ears (diplacusis). Although speech can be heard it frequently cannot be understood. The hearing

varies considerably and patients will state that at times they hear "perfectly" while at other times there is a "sense of pressure or fullness" in the ear and the hearing ability is impaired. Those patients who are musical complain bitterly of the difference in pitch appreciated by the two ears. Many patients state that loud sounds hurt the affected ear.

EXAMINATION

Usually the examination of the ear, nose and throat is unrevealing except for the functional tests of the ear.

AUDIOMETRY

Fork tests as a rule give characteristic findings of nerve deafness. The Rinne test is positive. The Weber is referred to the better ear. The Schwabach is diminished. Comparison of the sounds made by a tuning fork held close to each ear alternately reveals that the same fork may sound higher or lower in the affected ear than in the normal one. The sound, too, is not clear but is described as "fuzzy". Diplacusis may be present only in the low tones or only in the high, or maybe confined to only one frequency but it is nearly always present. This diplacusis can be measured. The pure tone audiogram reveals a threshold loss of hearing more marked in the low tones in the earlier stages later becoming a flat loss throughout the scale and still later showing a greater loss for the high frequencies. The bone and air thresholds are equal. Loudness balance tests reveal recruitment or hyper-recruitment. Speech audiometry is helpful in the diagnosis and characteristically shows a proportionally greater loss for discrimination than at threshold. We have found in our cases that where as the loss of threshold for speech is perhaps only 40 decibels the discrimination score is frequently less than 30%. On the contrary with lesions other than end organ lesions the threshold loss may be as great as 60-70 decibels but the discrimination score may be 50-60%. We feel this is an important point in the differential diagnosis between Meniere's Disease and lesions in the cerebellopontine angle. It confirms the observations of Eby and Williams and of Hallpike.

Caloric tests are not diagnostic in Meniere's Disease. In the early stages one may find equal responses in the affected and unaffected ear.

Later as a rule the affected ear becomes hypoactive and one may find a directional preponderance to the unaffected side. We use the Cawthorne Hallpike method of testing, douching with water 7° centigrade above and below body temperature for 40 seconds and timing the duration of nystagmus. In long standing cases one may get no response to stimulation of the affected ear even with maximum stimulation with ice water.

TREATMENT—MEDICAL

Although the etiology of Meniere's Disease is not known, there is accumulating clinical evidence which points to the possibility of a vasomotor change leading to spasm of the internal auditory artery. Such vasomotor change may be the result of an allergic state, for example, a true hypersensitivity to foods or inhalants. Endocrine imbalances, or psychogenic stimuli may have an effect. It is of importance to investigate all possibilities and eliminate the possible causative factors. However, such investigation is difficult and frequently time consuming and treatment should be instituted early. If the theory of a vasospastic state is correct, it is important to relieve this spasm and vasodilators have been recommended. Our routine has been the use of Roniacol or nicotinic acid 50 mg. together with thiamine chloride 10 mg. and ascorbic acid 250 mg. three times a day with meals. In addition Banthine, 50 mg. or Probanthine, 15 mg. is given every six hours. In some cases atrophine 1/50 Gr. t. i. d. by mouth has proved beneficial. In many cases this has prevented the dizzy spells, although in others even under such therapy the patients have had attacks.

Derlacki and Shambaugh emphasize the use of histamine in small doses. They recommend 0.1 cc of a 1 to 100,000,000 dilution as the test dose. If the patient improves as evidenced by the diminution of the tinnitus and a lessening of the vertigo, this dose is given twice a week. If no improvement, then 0.1 cc of 1 to 10,000,000 and subsequently 1 to 1,000,000 or 1 to 100,000 dilutions are used until the appropriate dose is found. When the appropriate dilution is found it is injected either once a week or twice a week. We have not had experience with this regime ourselves so cannot comment further about it. We have on many

occasions used intravenous histamine in an attempt to treat an acute attack but so far with no success. Fowler, sometime ago, suggested the use of large doses of streptomycin to destroy the vestibular function. The recovery from doses as large as 4 grams a day for three weeks is slow and the patient is ataxic and very uncomfortable for quite sometime. There is also, in this therapy, danger of further injury to cochlear function. Recently Schuknecht has employed streptomycin in doses of 2-3 grams a day but he has done caloric tests daily and hearing tests every other day and finds that if the drug is given properly the diseased labyrinth loses its activity without damage to the normal labyrinth. He further states that the hearing in his cases has been improved both in regard to threshold and discrimination. The dose of streptomycin must be very carefully regulated.

In a few cases we have used large doses of vitamin B₁₂ with apparent success. The dose is 1,000 micrograms intramuscularly daily for thirty days and thereafter as a maintenance dose at intervals to be determined. Although the cases that have benefited from this treatment are few, it perhaps warrants further trial. As an example a case report follows:

A 27 year old, white male was first seen in October 1951, sent in by his own otologist, complaining of ringing in his ears which started while he was in the service from 1943 to 1946. His first dizzy spell was in 1949. The dizzy spells had been more frequent in the past year. They were very severe and lasted four or five hours. His last attack before being examined by me was two months previously. He stated that the ringing in his ears became louder for about two hours before the dizzy spell started.

Examination of the ear, nose and throat was essentially negative. His tests showed a nerve deafness in the right ear, more marked in the low tones; a normal left ear. He had hyper-recruitment, a definite diplacusis at 4,000 cycles and his speech tests revealed a threshold loss in the right ear of 39 decibels with 44 per cent discrimination. The left ear had normal threshold with 96 per cent discrimination. He was considered for surgery because his work necessitated climbing on grain elevators and

he was afraid that he might have a dizzy spell at a time when he was on a height and might lose his balance and hurt himself. However, he was put on medical therapy in order to allow him to postpone surgery until after the new year. During this time he had vitamin B₁₂ injections daily for thirty days and in February 1952 he was retested and his threshold in the affected ear was now found to be 16 decibels with 94 per cent discrimination. He continued with his B₁₂ and has been tested on March 1952, October, November 1952, January and July 1953 and the last test was done on October 1953 at which time the hearing was normal in the right ear with 96 per cent discrimination. During this time he has continued with injections of vitamin B₁₂ at intervals of a week to ten days. He states that he can always tell when he needs an injection because the tinnitus increases. During the period he was on B₁₂ we gave him some placebo to inject; this happened to be phenol-sulfonphthalein. The ampule had the same appearance, color, and so on as the B₁₂. He returned after a few injections complaining that the material was not the same as he had before because he found that it did not stop his tinnitus and that he had had a dizzy spell. He was put back on B₁₂ and since then has had no further trouble.

Normal remissions in this disease make it difficult to evaluate therapy and one must be guarded in ascribing to therapy what may be the result of a normal fluctuation in the disease.

SURGICAL

When the patient has not been helped with medical management and has become incapacitated or handicapped by his disabling vertigo, destruction of the labyrinth will give complete relief to the symptoms, provided, of course, that the disease is unilateral. It is emphasized that labyrinthotomy is reserved for cases in which the disease is unilateral.

The operation of labyrinthotomy, which was first described by Day in this country, is a simple procedure performed either through an endaural or a postauricular approach as the surgeon desires. Enough mastoid cells are entered to allow for a direct approach to the horizontal semicircular canal and, particularly,

to its anterior end. I find it best to remove the incus and the head of the malleus to have an easier access to the vestibule. A large opening is made in the vestibule. The endolymphatic labyrinth is avulsed and after the area is carefully dried a coagulating current is applied to the vestibule in order to destroy both utricle and saccule completely.

Results from labyrinthotomy have been universally good if an adequate destruction has been done. If, however, the utricle and saccule are not completely destroyed, the patient, although he may have no true vertiginous attacks, may be unsteady and have difficulty on forward motion. A case: T. B. age 49, had had symptoms of Meniere's disease for many years. Caloric tests showed a complete absence of response from caloric stimulation in both labyrinths. He was constantly unsteady and complained that when he met people on the street and turned quickly to look at them he was apt to stagger and was frequently accused of being inebriated. A labyrinthotomy was performed and coagulation of the endolymphatic labyrinth accomplished. After the wound was healed he still complained of a sensation of unsteadiness, particularly, on forward motion. He stated that as he walked down the street the horizon would jump up and down constantly and it was a very disabling condition. Furthermore, on quick turning of the head when he was walking he would definitely stagger to his left side. A revision of the operation was performed and very careful destruction of the whole vestibular labyrinth was accomplished since when he has had no further disability.

There should be no danger from the procedure of labyrinthotomy. There have been reports of facial injury following coagulation of

the labyrinth. This is probably due either to improper placement of the coagulating electrode so that it approximates the underside of the facial nerve or possibly might be caused from heat in the area if the area is not satisfactorily dried before the current is applied, in effect boiling the under surface of the nerve. In any event if the patient does by misfortune wake up from the anesthesia with a facial paralysis following the operation no time should be lost before the nerve is completely decompressed.

SUMMARY

1. The term Meniere's Disease should be confined to those cases exhibiting the classical triad of tinnitus, vertigo and nerve deafness, the result of endolymphatic hydrops.
2. The functional tests of hearing are important in these cases and exhibit 1) a nerve loss usually flat throughout the scale of pure tone audiometry, 2) recruitment or hyper-recruitment, 3) diplacusis and 4) a comparatively great discrimination loss for the threshold loss of hearing for speech. Caloric tests may not be informative in Meniere's Disease but in long standing cases usually show a hypoactive labyrinth on the affected side.
3. Medical therapy with vasodilators, with histamine, or with B₁₂ may give some relief to the patient. The results of therapy should be estimated in the light of the known periods of remission in this disease.
4. The surgical ablation of the labyrinth will give complete relief in cases of unilateral hydrops provided a complete destruction of the vestibular labyrinth is accomplished. It is important that the utricle and saccule as well as the semicircular canals are destroyed.

Tinea Capitis

KATHLEEN A. RILEY, M. D.

Charleston, S. C.

Tinea capitis, commonly called "ringworm of the scalp", is a fungus infection principally involving the hair. It most frequently occurs in children before the age of puberty. The fungi causing this disease are *dermatophytes* of the two genera *Microsporum* and *Trichophyton*. The fungus invades the stratum corneum, the top layer of the epidermis. Later it enters the hair follicle, and finally, the hair shaft itself. These fungi infect only the epidermis and the epidermal appendages. They never invade the body to produce systemic disease.

SYMPTOMS:

The cardinal symptoms of tinea of the scalp are partial loss of hair in patches, breaking off of infected hairs, and varying degrees of inflammation. The inflammation may be as mild as simple scaling. It may be as severe as a painful, elevated, boggy, erythematous localized mass which is called a kerion. The kerion usually results in atrophy and scarring. The various types of *Microspora* and *Trichophyta* present different individual clinical pictures. These various clinical pictures will be described briefly:

1—*Microsporum audouini*: This fungus is transmitted by humans and is responsible for the epidemic forms of tinea capitis in children. It is almost never found in adults. It is one of the most common causes of tinea capitis in this country. This fungus is the cause of the classic picture of "gray patch" type lesions which seldom show anything but the mildest type of inflammatory reaction on the scalp.

2—*Microsporum canis*: This is the second type of ringworm most commonly found only in children. With *Microsporum audouini* it accounts for 90% of all tinea capitis in children. It is transmitted primarily from domestic animals such as dogs and cats, but occasionally may be transmitted from one child to another. It usually produces a greater degree of inflammatory response with resulting alopecia than is found in the simple "gray patch" type of tinea from *Microsporum audouinii*. This

form frequently involves the glabrous skin producing the typical tinea corporis, or ringworm of the body.

3—*Microsporum gypseum* or *Trichophyton mentagrophytes*: The primary lesions in these infections are immediately acute and severe. The tissue reaction involves the production of a kerion which is elevated, painful, boggy, erythematous, and studded with pustules. It leaves permanent scarring. These infections are not confined to children.

4—*Trichophyton tonsuraus*: A fourth clinical picture is the so-called "black dot" ringworm. This occurs in adults as often as in children. Until a few years ago it was considered unusually rare, but there is an alarming increase in its incidence over the southern part of the United States, and many predict an epidemic.^{1,2} How it is transmitted is not definitely known, but it is thought to be via animals and humans. The fungus invades the hair in such a manner that the hairs break off at the surface of the scalp and dark stumps in the hair follicles give the typical "black dot" appearance. It may appear to be simple dandruff and so go for years without treatment, thereby resulting in permanent scarring and alopecia.

INCIDENCE:

Tinea capitis has a world wide distribution. It was formerly considered more common in Europe, but in the last fifteen years has been very common in North America. Epidemics of *Microsporum audouini* infection have involved thousands of children over the United States and Canada. In Charleston, South Carolina, a series of one hundred cases proven by culture shows the infections to be distributed as follows:³

<i>Microsporum audouini</i>	50%
<i>Microsporum canis</i>	39%
<i>Microsporum gypseum</i>	5%
<i>Trichophyton tonsurans</i>	5%
<i>Trichophyton mentagrophytes</i>	1%
	—
	100%

DIAGNOSIS:

In a child with scaling lesions in the scalp, accompanied by hair loss, tinea capitis should always be considered first. The three procedures for diagnosis include: (1) The Wood's light examination. This light is a filtered ultra-violet light which causes hairs infected with *Microsporum audouini* and *Microsporum canis* to fluoresce a greenish color. This allows not only for quick diagnosis, but for the location of all infected areas; (2) The direct microscopic examination of the hair in a 10% KOH preparation; (3) Culture of the organism on Sabouraud's medium.

Identification of the type infection is important in determining the prognosis for the individual patient. It is also important for the community's welfare because of a possible epidemic due to *Microsporum audouini*.

TREATMENT:

At the present time there is no rapid or simple treatment for tinea capitis which is adequate. This is true because of the mechanical impossibility of getting any drug into the infected hair and hair follicle. Successful treatment is difficult and prolonged even with diligent application of the best principles of therapy.

These principles are: (1) The infected hairs should be clipped, not shaved. (2) Manual epilation of all infected hairs must be done. This is best done with a pair of regular eyebrow tweezers, taking care that the hair is pulled out and not broken off. This may sound like a painful procedure; however, since the hairs are loose in the follicle, they come out easily and epilation does not hurt. It must be emphasized that this is a tedious process and involves time and patience. Each hair removed is a possible source of infection, therefore should be placed in a piece of cotton or tissue and destroyed. The tweezers also will carry the infection and should be sterilized. Time taken to demonstrate the technique of manual epilation to the parent is well invested. (3) Daily thorough shampoo should be done. (4) Diligent local application should follow. Many forms of local drugs have been tried. No single drug is ideal, but the ones most generally successful are combinations of fatty acids and salicylanilide.^{4, 5} Asterol Dihydrochloride is

also thought by many workers to be worth while, especially in *Microsporum audouini* infection.⁶

A typical adequate routine would be as follows:

Morning—Shampoo followed by
fatty acid solution or Asterol
tincture.

Night—Manual epilation.

Ointment—Salicylanilide or fatty
acid or Asterol.

This program usually takes two to four months to effect a cure, depending on the diligence of the treatment, especially manual epilation. If results are poor after three to four months of therapy, then x-ray epilation should be considered, especially if the infection is a widespread non-inflammatory type, or if the parents and child are uncooperative. X-ray epilation should be done only by a qualified expert and is a tedious and difficult procedure. Even with x-ray epilation, the above outlined procedure should still be followed until the patient is cured. During the course of treatment, the patient should be checked at least every two weeks. If an acute secondary infection develops, a systemic bactericidal agent can be given.

Cure should be determined by lack of fluorescence under the Wood's light, supported by negative cultures on two repeated occasions at least one or two weeks apart. A negative Wood's light examination in itself is not an adequate criterion for cure because the fluorescence of the hair may be destroyed by some of the local chemotherapeutic agents before the fungus is eradicated. In general, the animal forms with severe kerion formation heal more rapidly and may involute because of spontaneous epilation. Those with little inflammatory reaction heal very slowly and require prolonged treatment. These do not tend to cure spontaneously. However, *Microsporum audouini* and *Microsporum canis* will tend to spontaneous cure at puberty because of the increased fatty acid content of the adult type scalp.

PREVENTION:

Since the majority of the cases of tinea capitis are contagious, prevention of its spread is very important. The simplest way to prevent

spread is for the infected person to wear constantly a washable cap or hat. Combs, brushes, and hats used by the infected person should be isolated and sterilized. He should sleep alone and linens should be isolated. He should not go to a public barber. If he does, the barber should be told of the infection and asked not to use clippers as they cannot be satisfactorily sterilized. All family pets should be examined if an animal type infection is found. If there is spread of tinea capitis in a community or a family group, all upholstery should be checked with the Wood's light. Infected hairs will stay in upholstered chairs, automobile seats, and theater seats where the child's head rests. Many believe children with tinea capitis should not attend school. However, this seems

to be an impractical approach to the problem as the infection is of such long duration. A child of school age should be able to cooperate and follow procedures to prevent spread.

REFERENCES

1. Howell, J. B., et al, Arch. Dermat. & Syph. 65:194 (Feb.) 1952, Tinea Capitis caused by *Trichophyton tonsurans*.
2. Pipkin, J. L., Arch. Dermat. & Syph. 66:9 (July) 1952, Tinea Capitis in the Adult and Adolescent.
3. Adams, A. S., and Riley, K. A. (in press), Tinea Capitis, A Report of One Hundred Cases.
4. Hopkins, J. G., et al, Arch. Dermat. & Syph. 67:479 (May) 1953, Treatment of Tinea Capitis with Salicylanilide preparations.
5. Scully, J. P. et al, J. of Invest. Derm. 10:111, 1948, The Local Treatment of Tinea Capitis due to *Microsporum Audouini*.
6. Edelson, E., & Haskins, A. H., Arch. Dermat. & Syph. 66:244 (August) 1952, Treatment of Superficial Mycological Infections with a New Antifungal Agent

Pathological Conference, Medical College of South Carolina

Dr. Vince Moseley: Mr. Underwood, will you present the protocol on today's conference.

Mr. J. A. Underwood: Present Illness: 24 year old white female admitted to Roper Hospital February 13, 1952, having been in coma for 15 hours after its sudden onset. At the age of 3 years she developed right foot drop which improved markedly after transplantation of Achilles tendon. Slow progressive weakness in right gastrocnemius and quadriceps. Later the left leg became involved, producing a scissors gait at the age of 11 or 12. Progressive loss of use and atrophy of lower extremities followed, with little control over motion. The right upper extremity subsequently became spastic and later moderate involvement of the left arm was noted. Right facial weakness and dysarthria developed just before admission. There were no headaches or visual disturbances. Because of dyspnea, auricular fibrillation, and edema 3 years ago, she was given crystodigin with excellent results. One month prior to admission, generalized abdominal pain, nausea, vomiting, and lethargy developed and lasted for 24 hours. Right strabismus of left eye and slight left exophthalmos appeared, but pupils were equal. Anorexia, loss of coordination in motion of hands and swallowing followed. At about 3:30 a. m., on the morning of admission, the patient began groaning with muscle pain. Lethargy and stupor became prominent. Cheyne-Stokes breathing, auricular fibrillation, and incontinence developed. Both eyes deviated to the right and there were tonic contractions of right facial muscles and the right upper and lower extremities. Following sedation all muscles became flaccid.

Past History: Family History: Father died at 31 of

lobar pneumonia. Mother and 6 siblings are alive and well. Had usual childhood diseases. Recent weight loss of 40 pounds. No familial diabetes, tuberculosis.

Physical Examination: T. 99, P. 88, R. 28, BP 104/58. Moderately well developed, slender, white female, comatose, with Cheyne-Stokes breathing. Skin: Color ashen. MM pale. Eyes: Right pupil appeared larger, eyes roving continuously. Lungs: Cheyne-Stokes respiration with 1-20 seconds apnea and marked hyperpnea. CV: Heart sounds of good quality with grossly irregular and rapid rhythm. Musculo-skeletal: Talipes left foot. Limbs flaccid. Neurological: Evaluation of cranial and spinal nerves difficult. Complete areflexia and flaccid extremities.

Laboratory Data: Feb. 14. RBC 5.19 million; WBC 22,700; Hgb. 15 grams; Monos 1; Lymphs 11; PMN 88. Urinalysis: Color—Cloudy yellow; reaction-acid; sp. gr. — 1.026; alb. — ++; sugar — ++++; acetone — ++++; pus cells — 4-5/HPF. RBC: 2-3/HPF; epith. cells — ++++; casts — 0. BUN: 25 mgm. per 100 c.c. Blood sugar: in A.M., 364 mgm.; per 100 c.c. at 4:00 P.M., 276 mgm. CO₂ combining power: 25 vol. VPC: 40 mm. Spinal fluid: cell count — 1; 100% lymphocytes and no RBC. Wass — QNS. Kline negative. Colloidal gold negative. Total proteins 52 mgm. Blood culture — pseudomonas aeruginosa.

Feb. 15. Serum sodium 376 mgm. Serum potassium 16.4 mgm. Blood sugar, early A.M., 272 mgm. 2:00 p.m. 58 mgm.

Feb. 16. BUN 54 mgm.; blood sugar 182 mgm. CO₂ combining power 61 vol.

Hospital Course: Feb. 13. Caffeine and sodium benzoate, penicillin, crystodigin and I.V. fluids given.

Feb. 14. At 4:00 a.m. intern called to see patient. Marked hyperpnea and very short periods of apnea persisted. Color poor but no cyanosis noted. Extremities spastic during periods of hyperpnea, but becoming flaccid with return of more normal respiration. Heart rate still very rapid and markedly irregular. Blood pressure hovered between 60-90 systolic throughout entire course. T. 103; P.120; R. 34 at 4:00 a.m. 250 units of regular insulin and I.V. fluids given. In afternoon Foley catheter inserted and 500 cc. urine obtained. Urinary output decreased. Character described as dark in color. Feb. 15. 2:00 a.m., only trace of sugar and no acetone in urine sample collected. Continuous O₂ by nasal catheter. Unable to detect pulse. Started developing another rhythm, shown by ECG to be probably complete heart block with several foci of ventricular ectopic beats, later trigeminy, and after rectal pronestyl hydrochloride, a reversion to probably auricular flutter with heart rate 160 per minute. Pronestyl discontinued. Given quinidine gluconate with reduction of heart rate to 150 per minute in 1 hour. Despite intensive therapy, progressive downhill course. She ceased breathing and had a heart rate of 72 per minute which was described as "regular". Very shortly the heart stopped and the patient was pronounced dead at 9:20 p.m. on Feb. 16.

Discussion: Dr. Vince Moseley conducting.

Dr. Moseley: Mr. Barr, this is an intriguing and somewhat complicated case for discussion today. Discuss for us the neurologic states up to the time of admission, giving us the diseases you considered up to this stage.

Mr. W. M. Barr: The most impressive thing is the foot drop which improved by transplantation of the Achilles tendon. Things which frequently cause foot drop are fibrosis of the muscle, upper motor neuron lesions, and position foot drop.

Dr. Moseley: This symptom developed at 3 years of age. Is there any significance to that?

Mr. Barr: It would cause one to think of a congenital lesion, or a chronic progressive disease of muscles, or some other chronic disease such as ataxia or something of that sort. In addition, a lower nerve lesion, for example spina bifida, nerve compression or a meningitis might be considered.

Dr. Moseley: What about an infectious neuritis?

Mr. Barr: Poliomyelitis must be considered. The chronic course would be against poliomyelitis and also the progressiveness of the lesions. Also the observation of a scissors gait at 11 or 12 years is against poliomyelitis.

Dr. Moseley: What would be the significance of the scissor gait?

Mr. Barr: It would indicate some condition leading to an adductor muscle spasm.

Dr. Moseley: The patient is said to have had a bilateral Babinski. Do you think it was present at that time?

Mr. Barr: Yes, I think it could easily have been and it cannot be ruled out. The loss of control and emo-

tional disturbances would point to an upper neuron lesion. This would tend to indicate an ataxia or athe-
thoid characteristic.

Dr. Moseley: What two types of neurologic disease would give us a loss of proprioception?

Mr. Barr: Either a cerebellar lesion or a dorsal column injury.

Dr. Moseley: What about the dysarthria? Does this help?

Mr. Barr: Some cranial nerve is involved, probably the 9th or 12th. The 5th has motor fibers, but does not go into the cord.

Dr. Moseley: What about the cerebellar lesions?

Mr. Barr: Yes, this would cause it.

Dr. Moseley: We have spasticity and ataxia and they are progressive, later involving upper extremities, then facial weakness developed. What diseases must we think of?

Mr. Barr: We must think of a cerebellar lesion and pyramidal disturbance. These are found in such conditions as hereditary ataxia or disease of neurons with a progressive course. A brain tumor may be considered, but it is difficult to focus in time over this long a period and the progressive ascending distribution.

The most common lesion to fit this condition is Friedreich's ataxia. It is said in the books that sporadic cases occur. I think this case would fit the picture of Friedreich's ataxia very well with pyramidal tracts being involved which account for the spasticity. The rest of the symptomatology can be so disturbed as to give any kind of picture. The course of the disease could fit in very well. Talipes equinovarus is one of the first signs observed. There is no scoliosis.

Dr. Moseley: What about the terminal event?

Mr. Barr: We have weight loss and anorexia which looks like diabetes. The upper extremities showing flaccid paralysis with a sudden onset of coma, the albumen, sugar, and acetone are significant. One thinks of diabetes or cardiovascular accident, but she had acetone and I wouldn't think cardiovascular accident would cause that. However, the complete dehydration and starvation could account for it. She was acidotic, with carbon dioxide combining power of the plasma below 20. There is elevation of blood sugar and spinal blood sugar. In addition, there is a positive culture of pseudomonas aeruginosa. This may be a contaminant, but there might be a septicemia or bacteremia. There is no evidence of meningitis. An acute fulminant septicemia might produce this situation without cells in the spinal fluid. When intravenous fluids and 250 units of insulin were given the sugar came down to 58. It does not indicate that the diabetes was controlled and she didn't improve.

Dr. Moseley: What about the cardiovascular system?

Mr. Barr: About three years ago she had auricular fibrillation and was digitalized with some improvement. This was the cause for the consideration of heart disease. Mitral disease or thyrotoxicosis are

possibilities. I think we can eliminate thyrotoxicosis. One must consider coronary artery disease or syphilitic heart disease. The disease I think most likely is rheumatic heart disease.

Dr. Moseley: Of all types of rheumatic heart disease, which one most frequently has fibrillation?

Mr. Barr: Mitral stenosis.

Dr. Moseley: What is the diagnostic sign?

Mr. Barr: Diastolic murmur, and when fibrillation occurs the murmur disappears so you can't rule out mitral stenosis.

Dr. Moseley: Something happened one month before admission—nausea, vomiting, lethargy, etc. She improved and another acute onset suggesting some cerebral lesion with strabismus and pupillary change and roving eyes. Can this be tied together?

Mr. Barr: I would think Friedreich's ataxia is the best bet as the diagnosis. In addition, there is sometime involvement of the heart with auricular fibrillation. There could easily have been repeated emboli to the brain. She could have had emboli to the adrenal or some infectious process in the adrenals.

Dr. Moseley: Does someone else care to comment? Mr. DeVore?

Mr. Robert H. DeVore: My idea was very much the same as Mr. Barr's, but I did consider other things such as disseminated multiple sclerosis. Two-thirds of the cases begin between 20 and 40 and start off with a pyramidal tract lesion such as foot drop. I don't think it is the case here because there are usually visual disturbances by retrobulbar neuritis, and paresthesias. There were no exacerbations and remissions.

Dr. Moseley: What about the bacterial implications?

Mr. DeVore: I don't believe that the pseudomonas aeruginosa is usually involved in a subacute bacterial endocarditis. I would like to discount pseudomonas as a contaminant.

Mr. R. M. Johnson: I think we have made an all too obvious omission; that is the possibility of porphyrinuria. In this condition we would have a similar situation except for the muscular distribution. The acute acquired type can produce this symptom complex, although there would be exacerbations.

Mr. M. G. Evans: I did entertain the idea of a tumor. Certain tumors such as craniopharyngioma. She may have had a medulloblastoma in the cerebellum.

Dr. Moseley: Do any of the staff wish to comment?

Dr. F. E. Kredel: Cerebellar medulloblastoma usually has a more rapid course than this. I tend to interpret this as a cerebellar ataxia or a Friedreich's type of ataxia with the development of diabetes.

Dr. Moseley: A subacute bacterial endocarditis could precipitate a diabetes. Another possibility might be that an acute pancreatitis could develop and explain the diabetic symptoms.

Dr. J. T. Cuttino: (Closing) This is a classic case of Friedreich's ataxia from pathologic anatomic state.

I call your attention to these slides. As you see here the spinal cord is smaller than normal. There is extensive atrophy. You see the demyelination in the portion of the cord usually occupied by the lateral cortico-spinal tract. This is bilateral. It is true that it is more intensive in appearance in the area occupied by the lateral cortico-spinal tract, but it is also to be seen in the ventral portion of the cord in the vicinity of the ventral cortico-spinal tract. In the phosphotungstic acid hematoxylin preparation you see, in addition, an extensive gliosis. In this particular case it is of interest that the dura is markedly thickened. This is not the usual finding in Friedreich's ataxia and I call your attention to one other finding which is also not the usual occurrence. That is: there is a marked sclerosis of the arterioles.

As you know, our knowledge of the etiology of Friedreich's ataxia is extremely confused. That it is a heredito-familial disease has raised the point that it might be congenital. The finding of arteriosclerosis focuses our attention on the possibility of a vascular causation of Friedreich's ataxia. That this might also be congenital is apparent. One reads numerous reports of arteriosclerosis in small children, especially in coronaries. One reads further reports of vascular disturbances in Friedreich's ataxia. For example, there is a report by G. W. Manning¹ of 6 cases of which 4 had T-wave changes indicating coronary disease. Unfortunately, autopsies were not reported. Nades² reports additional cases showing coronary disease. So that it seems to me reasonable to believe that there is a vascular causation and this fits in with the appearance of the cord. You may recall that we have had several cases in this same series of Clinico-Pathologic conferences of subacute necrotic myelopathy in which there was a vascular change and in those cases it has been suggested that a vascular disturbance was present.

Can we substantiate this by other findings in this case? This can be very well done in that in the heart there was extensive coronary sclerosis with a diffuse fibrosis and what was formerly called myocarditis. Upon this lesion was superimposed a mural thrombosis. Emboli were liberated and lodged in the spleen, kidney and brain which you can see in these sections. (Demonstrating sections). It is of interest that this mural thrombosis must have been present for some little time in view of the fact that the areas of encephalomalacia in the brain are both new and old and as you note here an organized blood clot in one of the vessels.

In reconstruction then, one recognizes this case as a case of Friedreich's ataxia. The question is presented as to whether or not, at least in this instance, the Friedreich's ataxia was caused by vascular obstruction. This is borne out by the evidence of vascular disturbance in the form of arteriosclerosis, arteriosclerosis and myocardial degenerations with mural thrombosis and embolization of the kidneys, spleen, and brain. That this patient probably died in a cir-

culatory failure is indicated by the central necrosis in the liver.

REFERENCES

1. Manning, G. W. Cardiac Manifestation in Fried-

reich's Ataxia. *Amer. Heart J.* 39: 799-816, June 1950.

2. Nades, Alexander S., Mariano M. Alimurung, Louis A. Sieracki. Cardiac manifestations of Friedreich's Ataxia. *New England J. Med.* 244: 239-244, February 1951.

In spite of the scientific triumphs over disease, can it be possible that the physician himself is today in danger of losing the faith and the affection of the people and his time-honored position in society? Dr. Howard Taylor voices this fear when he suggests that "The people are vaguely dissatisfied with the doctor as a person, for they feel that he has become too commercial or too scientific, too busy or too preoccupied to concern himself with their problems."

Who is responsible for this sorry state of affairs? Again within and without the profession, the accusing finger is pointed at the physician's education. This is the culprit who needs to be chastized and reformed. Science, ever more science, they say, is crowding into the educational program and pushing aside the humanities and the social sciences. Lord Horder recently wrote, "The student's pre-medical program is lopsided; almost from the moment a boy or girl decides to be a doctor, the confines of his or her interest tend to become more and more narrow. Medicine, which should have the widest contacts of any profession, almost ceases to be a liberal education, for its cultural outlook dwindles from this moment."

What added acclaim would be Sir William Osler's today were he able to say again what he wrote many years ago, "The wider and freer a man's general education, the better practitioner is he likely to be, particularly among the higher classes to whom the reassurance and sympathy of a cultivated gentleman of the type of Eryximachus may mean much more than pills and potions. In no profession does culture count for so much as in medicine, and no man needs it more than

the general practitioner, working among all sorts and conditions of men, many of whom are influenced quite as much by his general ability, which they can appreciate, as by the learning of which they have no measure."

A. E. Severinghaus
J.A.M.A. 155:417

PITT SOCIETY OF NORTH CAROLINA ASSURES MEDICAL CARE FOR ALL


The Pitt County Medical Society has adopted a program designed to provide the services of a qualified physician to everyone in the county regardless of ability to pay, according to the County Secretary, Dr. E. W. Larkin, Jr.

The program is centered around the Pitt County Memorial Hospital. As a matter of policy, there are no doctor's offices in the hospital. However, a complete "service" staff is on call at all times. A patient coming to the hospital is referred to the doctor covering the service concerned; service appointments are rotated periodically, some monthly, some daily.

Since there are no internes, the hospital staff members voluntarily take their turn in rotation at staying at the hospital from 7 p. m. to 7 a. m. to handle emergencies during the night. The doctor who serves as interne handles everything that he can; if something comes up for which he feels he is not qualified, he calls whoever happens to be covering the service concerned.

The program as outlined above is considered by the society to be successful in providing the needed service.

Public Relations Bulletin—Med. Soc. of State of N. C.



Give the United Way!

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

EDITORIAL BOARD

J. P. Cain ----- Mullins
J. D. Guess ----- Greenville
C. J. Milling ----- Columbia
H. R. Pratt-Thomas ----- Charleston

Vince Moseley ----- Charleston
Ben Miller ----- Columbia
W. H. Prioleau ----- Charleston
J. W. Jervey ----- Greenville

G. D. Johnson ----- Spartanburg
R. M. Pollitzer ----- Greenville
Hugh Smith ----- Greenville
Walter Mead ----- Florence

BUSINESS MANAGER: Mrs. C. G. Watson

105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor)

Charleston, S. C.

Subscription Price

\$3.00 a Year

OCTOBER, 1954

Choice of Physician in England

Under current arrangement, members of the British labor unions have had to select physicians in the panel system or pay the private physician out of their own pockets. Now provision is being made by British companies for "fringe benefits" in the form of pre-paid medical plans which pay the cost of the private physicians care.

Evidently the workers prefer private doctors of their own selection. After surrendering their free choice, they now seem to repent and want to return to the arrangement which held good before the days of socialized medicine.

From our point of view, this is a healthy relapse.

Southern Medical Association

The annual meeting is to be held in St. Louis, November 8-11, 1954. A large and fruitful meeting is anticipated.

South Carolina is well represented in the organization. Dr. W. Thomas Brockman is a Councilor, Dr. Vince Moseley is Chairman of the Section on Medicine, Dr. R. Wilson Ball is Chairman of the Section in Public Health, Dr. Wm. McCord is Vice Chairman of the Section on Medical Education and Hospital Training.

Various other societies will meet conjointly with the Southern Medical Association.

Cortisone

An editorial in The New England Journal of Medicine* describes the receding tide of enthusiasms over cortisone, and quotes a statement made in April 1953 by Dr. Edgar S. Gordon: "... the use of ACTH and cortisone in chronic diseases is becoming less and less

justified, probably on the basis of the over-all, long time results, plus a great many complicating factors, including some which are quite dangerous. There are a good many of the best arthritis clinics in the country, for example, which have discarded cortisone therapy completely and have gone back to older methods . . ."

Recently in England further emphasis of discouragement was reported, especially as concerns prolonged use. A carefully controlled comparison of the effects of cortisone and aspirin, used over a period of a year, showed that there was no really appreciable difference in their effects.

An editorial note ends: "It would be ironical if the major practical outcome of the intensive work of the last few years is the discovery that aspirin, given in maximum tolerated doses, is the best and safest treatment for rheumatoid arthritis, the only common disorder for which cortisone is used."

*251: Aug. 26, 1954, 359-360.

Gamma Globulin

There has just appeared a new analysis* of the data on which the claim has been founded that gamma globulin is an effective modifier or preventive of poliomyelitis. Careful consideration of many factors brings conclusions somewhat different from the earlier statements.

A rigid selection of cases of polio showed that many cases diagnosed as polio were due to other viruses or did not show the presence of a virus. Roughly 30% of cases were in this class, a finding which only throws more confusion in the clinician's eyes.

The results of the study are qualified with many vague statements, e.g. (The italics are ours)

"Although the number of cases occurring during the first week is quite small, the direction of observed difference *suggests* that, as in measles and probably hepatitis, if prophylaxis in the late incubation period fails to prevent, it may modify.

"The more accurate data based only on laboratory-confirmed cases lend support to the hypothesis that antibody given during the incubation period has a beneficial effect that can be interpreted either as modification or as prevention, depending on the type of examination and threshold used to determine the existence of muscle weakness. Therefore, unless better evidence has become available, use of gamma globulin after recognized exposure among family contacts or any other contacts of known cases is supported by *suggestive, though admittedly inconclusive, experimental data*. At least, there is no basis for concluding that gamma globulin will not protect under such conditions.

"The results support the effectiveness of use of the agent in suitable circumstances in mass immunization and also suggests its effectiveness in family contacts. *Evidence for both is far from adequate* but tends to confirm the earlier controlled tests.

"There appears to be definite evidence from the controlled studies that gamma globulin protects when given under suitable circumstances. *It is regrettable that these circumstances cannot be more completely described*, but the experiment was designed to answer one basic question: 'Will this amount of antibody prevent poliomyelitis under any conditions if natural exposure?' and not, 'How can gamma globulin be used most effectively in controlling the disease?' *No experiment has been performed yet to answer this second question.*

"These data offer very *suggestive, although not conclusive*, evidence in support of the use of gamma globulin after exposure has occurred."

These are not the positive results which would justify the enthusiasm of the National Foundation for Infantile Paralysis in recom-

mending widespread use of gamma globulin, and in beating the drum for more money for more globulin. The N. F. I. P. has sunk many millions in a great stock of gamma globulin which we do not know exactly how to use, but which must be justified in view of past claims, and must be used to keep the public in a state of constant contribution of blood, sweat, and dimes.

*J.A.M.A. 156, Sept. 4, 1954 21-27.

Founders Day

The Medical College will celebrate Founders Day with a Post-graduate Seminar on November 2, 3, and 4. On the first two days members of the College faculty will present a variety of subjects. On November 4 speakers from outside the state will give four presentations. A program is found elsewhere in this issue of the Journal.

On this same day there will be two special events. One will be the presentation of a portrait of Dr. William Weston at 11 A. M. This portrait is provided by a large number of Dr. Weston's friends and admirers, and was painted by Charles Crowson of Columbia.

In the afternoon, at the time of the Dedication Exercises of the Alumni Memorial House, there will be presented a plaque of Dr. D. Lesesne Smith, who played such a large part in alumni activities. This is given by his family.

Social activities include a buffet supper on Wednesday evening and a luncheon on Thursday. There will be no Founder's Day banquet this year.

The Bricker amendment missed passage by one vote in the Senate last year. It has been introduced again, and warrants the support of all physicians who are concerned with the danger of having various forms of socialized medicine foisted upon them by agreement between nations without individual sanction.

The new Bricker resolution reads: "Section 1. A provision of a treaty or other international agreement which conflicts with this Constitution, or which is not made in pursuance thereof, shall not be the supreme law of the land nor be of any force or effect. Sec. 2. A treaty or other international agreement shall become effective as internal law in the

United States only through legislation valid in the absence of international agreement."

The A.M.A. favors the Bricker amendment as a safeguard against the imposition of domestic law, (including laws affecting medical practice), through treaties.

In our AMA Washington Letter, we note that matters are progressing on "the administration's health program for constructing chronically ill hospitals, nursing homes—". Seems like a poor idea to build that kind of a structure. Too many of our hospital buildings are already chronically ill.

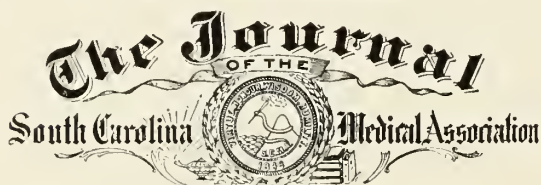
The same letter says that poliomyelitis cases are 7% behind the total for this time last year, yet the National Foundation for Infantile Paralysis gives as one of the reasons for a second March of Dimes the fact that there is a great increase in its case load. Maybe it's time for a mild retreat.

SPECIAL OFFER!

NEW COOK BOOK FOR
LOW SODIUM PATIENTS.

Adv. in J.A.M.A.

We are willing to admit that there are plenty of low patients, but this sodium patient is a rather strange one. Maybe he is a remote descendent of one of those patients from Sodium and Gommorrah.



Forty Years Ago

OCTOBER 1914

Dr. R. M. Pollitzer's paper on "Caloric Feeding in Infancy" appeared. Dr. J. R. Young discussed papers read before the Anderson Society. The budget of the Medical College was \$29,500.

STATE BOARD OF HEALTH

Excerpts from Minutes

The Executive Committee of the State Board of Health held a regular meeting on

Wednesday, July 21, 1954.

The report of the State Health Officer was read by Dr. Peebles.

It was moved by Dr. Boone, seconded by Dr. Barron, that the State Health Officer be given authority to exchange 18 second-hand automobiles formerly used by the Venereal Disease Section for eight new cars. Passed.

Dr. Ball reported that reduction in fees for orthopedic surgeons would definitely affect the Crippled Children's program unfavorably. He requested that the Executive Committee hold in abeyance its previous instruction to reduce the fees for orthopedic surgeons. It was moved by Dr. Hanckel, seconded by Dr. Barron, that the reduction of fees of orthopedic surgeons be postponed provided the budget be not exceeded, until Dr. Ball can make an investigation of all factors involved and report back to this Committee. Passed.

It was moved by Dr. Barron, seconded by Dr. Hanckel, that the attached appreciation of Dr. Wyman be approved by the Executive Committee, entered in the minutes of this Committee, and copies sent to the family of Dr. Wyman and to the Journal of the South Carolina Medical Association. Passed.

It was moved by Dr. Barron, seconded by Dr. Hanckel, that physical examinations be required of all new employees of the State Board of Health. Passed.

NEWS

PHYSICIAN DRAFT

For the first time in 16 months, the Army is scheduled to call up a group of physicians under the doctor draft. The Defense Department late in August instructed Selective Service to call up 550 physicians for induction in December. The department said 100 are required for the Army, the first draft since August, 1953; 250 for the Navy; and 200 for the Air Force. In addition, the Air Force will require 150 dentists, the first to be called since last May. Officials indicated that the physicians to be drafted would be drawn from priorities 1 and 2 and, to some extent, from priority 3.

—J. A. M. A.

Dr. C. G. Hoppers, Jr., Gaffney, S. C., this week opened his office for the practice of medicine in the office formerly occupied by Dr. Carl Parker in the Herbert Smith building over Clover Drug Store, at Clover.

Dr. Robert J. Schmoll opened his office in Greenville on July 1, 1954. He is limiting his practice to ophthalmology.

Dr. Foster N. Martin, native of Newberry, has returned to Newberry as general practitioner in medicine. Dr. Martin prior to returning was on the staff at Tulane University, New Orleans, La.

Dr. John A. Siegling, professor of orthopedic surgery at the Medical College of South Carolina, spoke before the Greenville County Medical Society in August.

The meeting was held at Shriner's Hospital for Crippled Children, which has played host to the society at its August meeting each year for about 15 years.

H. M. Allison, M. D. and L. N. Bellew, M. D. announce their association in the practice of obstetrics and gynecology at 907 Pendleton Street, Greenville, South Carolina

Lewis J. Moorman, M. D., will be long remembered by his colleagues and former students, as well as all who have read "Pioneer Doctor"—the account of his own early experiences. His death on August 2, 1954, terminates 15 years of service as the Editor-in-Chief of the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION.

Dr. Ruth Smith Johnson opened her office for the practice of Pediatrics on August 18 at 506 West Palmetto Street in Florence.

Dr. Tom. J. Lattimore, general surgeon, has set up offices at 809 Lancaster Street in Aiken.

Dr. R. H. Hand, an obstetrician and gynecologist, has opened his office in the McWhorter Building on North McDuffie Street, Anderson.

Dr. E. H. Reeves, Jr. has opened offices for the general practice of medicine and surgery in Laurens.

Dr. H. LeRoy Brockman of Greer, has formed an association for the practice of general surgery with Dr. L. G. Able, of Spartanburg, with offices in The Wellington, 349 East Main Street.

Dr. C. H. Haynsworth recently assumed his duties in association with Dr. Lamar Lee and Dr. Frank Lee at Saunders Memorial Hospital in Florence.

Dr. Robert C. McLane of Pelzer and Greenville will practice in Belton, associated with Dr. K. M. Waggett.

Dr. E. G. Norwood, of Bennettsville has become an associate in the practice of general medicine with Dr. Frank L. Martin, in Mullins.

Dr. Thomas E. Fulgham, of Augusta, an eye, ear, nose, and throat specialist, announced that he will establish practice in Bamberg.

Dr. Harry S. Allen, Jr., a native of Florence, has opened an office for the practice of internal medicine at 248 S. Irby Street.

Dr. C. P. Ryan, Jr., has arrived in Ridgeland and is engaged in the practice of medicine. He has remodeled and furnished offices for himself in the Ryan Building on Main Street.

PEE DEE MEDICAL MEETINGS

Note: All Meetings Are Held On The Third Thursday.

October 28 — Florence—ANNUAL MEETING—Speakers to be announced.

November 18—Chesterfield—Barbecue and Atomic Medicine: speaker, Dr. C. A. Andrews, Clinical Director of the Medical Department, Institute of Nuclear Studies, Oak Ridge, Tenn.

December 16 — CHRISTMAS PARTY AND LADIES NIGHT—Joint effort of Association to be held in central location to be announced. Dinner Dance, floor show, corsages, favors.

Dr. M. W. Beach was elected State Chairman of the South Carolina Chapter of the American Academy of Pediatrics on September 14.

DEATHS

DR. A. P. McELROY

Dr. A. P. McElroy, 78, prominent Union physician, died at his home on August 10, after a one year illness.

Dr. McElroy was a graduate of The Citadel and the Medical College of South Carolina at Charleston, serving his internship at Roper Hospital.

He moved to Union in 1909 where he first started practice of medicine. Dr. McElroy served in World War I as a captain and saw duty in France. He was past president of the Association of Surgeons of the Southern Railway, past commander of the American Legion, chairman of the commission of Public Works and a trustee of the Union Carnegie Library.

DR. GARDEN CLARKSON STUART

Dr. Garden Clarkson Stuart, 76, of Eastover died on August 24 in the Columbia Hospital.

Doctor Stuart was born in Washington, D. C., May 14, 1878, the son of the late Rev. Albert Rhett Stuart and Sophie Clarkson Stuart.

He was a life time resident of Richland county and was a member of Zion Episcopal Church. Doctor Stuart was an honorary member of the Medical Association and had practiced medicine in Eastover for more than 45 years.

DR. WILLIAM JOEL PERRY

Dr. William Joel Perry, 76, physician of Chesterfield, died on August 28.

Doctor Perry was in declining health since he suffered a coronary thrombosis in 1943. Death came from a paralytic stroke.

Doctor Perry was born in Union County near Wingate, N. C. In 1900, he was graduated from the Atlanta College of Physicians and Surgeons, now Emory University, in Atlanta, Ga.

In 1906-07 he continued the study of medicine and surgery at the New York Polyclinic. Upon graduation from Emory, he settled in the Taxahaw community, near Lancaster, and began the practice of medicine.

He took an active part in the life of the community, as a member of the Baptist Church, superintendent of the Sunday school and as a Mason. In 1909, at the request of a number of prominent citizens of Chesterfield, he moved there, and for more than 40 years continued to serve the people of that county as physician, legislator and friend.

DR. WILLIAM BOYKIN LYLES

Dr. William Boykin Lyles, 77-year-old prominent Spartanburg physician died September 11.

Doctor Lyles, a Fairfield County native, was past president of the Tri-State Medical Association and the Urological Association of South Carolina.

The son of the late John Woodward and Susan Morris Lyles, he attended South Carolina College (the University of South Carolina) was graduated from the Medical College of Virginia, practiced medicine at Georgetown, moving to Spartanburg in 1907 where he did general practice several years.

After a year's post-graduate work at John Hopkins and at Post-Graduate Hospital at New York City, he returned to Spartanburg and did urological work exclusively, pioneering in this speciality in the Piedmont Carolinas.

BOOK REVIEWS

PLANNING FLORIDA'S HEALTH LEADERSHIP by Russell S. Poor, Ph.D., Univ. of Florida Press, Gainesville, 1954. Price \$1.50.

Russell S. Poor, Ph.D., Provost, The J. Hillis Miller Health Center, has written an informative brochure, emphasizing the fact that the extension and improvement of medical facilities have not kept pace with the rapid growth of population; and that in Florida, as in other states, the need for doctors has become increasingly acute.

This publication is one of the Medical Center Study series that have been issued following a mandate of the 1949 Legislature, that a Medical School and a School of Nursing be established at the University of Florida. A university faculty committee of twenty was asked to outline a research study which would chart a course of action for the functioning of the two schools within the framework of the University.

Following a foreword, and introduction, the summary discusses the following items:

1. Florida's Need for Medical and Related Education.
2. Florida Center of Clinical Services: Inter-departmental Cooperation.
3. Medical Education in a University Setting.
4. Health Center Units.
5. Southern Regional Implications and Inter-American Relationships.
6. Administration, Personnel, Finances, Time Schedule and Principal Recommendations.
7. Recent Developments. A brief bibliography of medical education, and related fields, completes the summary.

The summarized Medical Center Study presents a framework for a program designed to train the necessary leadership for the improvement of health of the people of Florida and the surrounding region.

Twelve items are discussed which include a recommendation to plan schematically a completely integrated building to house all parts of the Health Center: a College of Medicine, a College of Nursing, a College of Pharmacy, a College of Dentistry, a University Teaching Hospital, an Auditorium, and a lodging unit for patients requiring prolonged diagnosis and treatment.

The study also recommended that various means of cooperation be undertaken in a program of education and service with state and federal Health and Welfare Agencies, and also to outline ways in which the University of Florida Health Center may contribute to the improvement of medical education and the betterment of health throughout the southern region; and to analyze the significant medical needs of middle and South American countries and to suggest ways in which the University Health Center may cooperate with these countries.

The Summary represents a group of practical suggestions, which may well serve as a blue print for health leadership, not only in Florida, but in other places, where there is an evident shortage of physicians and a lack of proper teaching facilities.

Leon Banov, M.D.

ILLUSTRATIVE REVIEW OF FRACTURE TREATMENT by Frederick Lee Liebolt—Lange Medical Publications, Los Altos, California—1954. Price \$4.00.

This is an excellent treatise of fracture treatment in a very brief and readable form.

Dr. Liebolt begins with the anatomy and physiology of bone giving the essential data in a concise manner that can be reviewed very easily. His illustrations throughout the book are excellent both from the point of view of the type of injury sustained as well as the causative agent.

This book is heartily recommended for medical students and house officers, however, it is this reviewer's opinion that much of the treatment is made to look much more simple than it actually is. It is hoped that the general practitioner will not read the book and feel that complicated fractures are easy to treat.

S. Edward Izard, M.D.

BEYOND THE GERM THEORY, The Roles of Deprivation and Stress in Health and Disease by Iago Galston, M.D., A New York Academy of Medicine Book. Published by Health Education Council, 10 Downing Street, New York, 14, New York. Price \$4.00.

The title of this book suggests that a new theory is to be expounded, while in reality the several papers included stress the fact that many factors other than infection are of major importance in the consideration of morbidity in practice and in public health. The book is in the nature of a sequel to "The Epidemiology of Health." The concept of "homeostasis" and the importance of stress of various kinds are outlined in an interesting manner, and the idea is offered that these important factors are possibly often neglected because of too much concern with germs and their toxins.

Some of the material is in the nature of a summary of well recognized facts and concepts, and tends to emphasis rather than to revelation. Perhaps to many readers the concept of deprivation, physical and emotional, as stress will be rather unusual, but obviously fitting.

Nutritional deprivation, the stress of pregnancy and its effect on the infant, psychological deprivation and stress at all ages, especially in infancy, and other related matters are discussed by a number of eminent authorities.

There are some statements which are a little hard to accept, such as the remark that 75% of women rejected the fact of pregnancy in the first trimester, and only a third had been reconciled by the third trimester. The source of such information must have been an unusual group or the circumstances must have been exceptional. Is it the biological fact or the economic or social implications which are rejected? A chapter on the serious effects of emotional deprivation in infants in a nursery and in a foundling home expounds in more scientific manner a fact that every good pediatrician has long known, viz: that TLC ("tender loving care," to the uninitiated) is a vital ingredient in all treatment.

This reviewer stumbled over a few unfamiliar words in this very good book. Especially at his age was he concerned with *geron*, probably a well accepted term, but alas, only two letters removed from *moron*.

J.L.W.

Give the United Way!

MEDICAL COLLEGE OF SOUTH CAROLINA

Tentative Program For Post-Graduate Seminar and Founder's Day November 2-4, 1954

Tuesday (November 2) A. M.

- 8:30 Registration and Greetings
- 9:00 A Case Report—Dr. W. E. Ector
- 10:00 Tetanus—Dr. M. W. Beach and Dr. Margaret Q. Jenkins
- 11:00 A Case Report—Dr. Wm. B. Gamble, Jr.
- 12:00 Diarrhea—Dr. J. R. Paul, Jr.

Tuesday P. M.

- 2:00 Management of Cardiac Arrhythmias—Dr. R. M. Anderson
- 3:00 Treatment of Hyperpotassemia—Dr. Vince Moseley
- 4:00 Therapy with Streptococcal Enzymes—Dr. C. deSaussure
- 5:00 Chronic Arsenic Poisoning—Dr. Robert Wilson

Wednesday (November 3) A. M.

- 9:00 The Diagnosis and Treatment of Genital Infections—Dr. J. R. Sosnowski
- 10:00 Abortion—Etiological Factors and Treatment—Dr. Fraser Wilson
- 11:00 Medical Complications of Pregnancy—Dr. James M. Wilson
- 12:00 The Diagnosis and Treatment of Eclampsia—Dr. L. L. Hester, Jr.

Wednesday P. M.

- 2:00 Nerve Blocks for Relief of Pain in Advanced Cancer—Dr. John Brown and Dr. F. E. Kredel
- 3:00 Acute Gastro-Intestinal Hemorrhage—Dr. Henry W. Mayo, Jr.
- 4:00 Local Treatment of Burns—Dr. Robert F. Hagerty
- 5:00 Hydrocortisone Injection of Joints and Bursae—Dr. R. M. Paulling
- 7:00 Buffet Supper and Roundtable Discussion

Founders' Day—Thursday—November 5

- 8:30 Registration & Greetings
- 9:00 Emergency Conditions of the Newborn Infant—Dr. McLemore Birdsong, Asso. Professor of Pediatrics, University of Va.
- 10:00 Renal Deficiency Associated with Secondary Shock—Dr. Virgil H. Moon, Research Professor of Pathology, University of Miami
- 11:15* Some Aspects of Cancer Research—Dr. William E. Smith, New York University—Bellevue Medical Center
- 12:15 The Rheumatoid Arthritic Cripple: Total Rehabilitation—Dr. Edward W. Lowman, New York University—Bellevue Medical Center
- 1:30 Lunch—Medical College; Alumni Memorial House
- 2:30 Dedication Exercises of Alumni Memorial House
- 3:30 Inspection of Dormitory

*At 11:00 Coffee Break: Alumni Association, School of Nursing

PRESIDENT'S PAGE

Though the re-insurance plan of President Eisenhower and Mrs. Hobby was defeated during the recent session of Congress, it is evident that this Administration is more liberal than we first thought in reference to so-called "social medicine." It is to be remembered that both the above-named bill and the inclusion of physicians under the social security scheme would have been passed had it not been for the active opposition of the medical profession. It now appears that no matter whether the Administration of this country is in the hands of the Republicans or the Democrats the medical profession must carefully scrutinize all bills introduced in Congress which have a bearing upon us.

While voluntary insurance plans and better public relations are of importance, it would appear that our most effective antidote against socialized medicine lies in the hands of the individual practitioner. If each American citizen might have a family physician and medical advisor to whom he knows he can turn when he or members of his family are ill; on whom he knows he can depend for treatment; that the cost of such treatment shall be within reason in proportion to his income, then socialized medicine will cease to be a factor in this country. If each call from a layman to any physician in America is answered in a tactful and diplomatic way and if every effort is made by the physician or his representative to see that that call is taken care of either by the physician called, by one of his confreres, or possibly seen temporarily by a registered nurse who represents him, the proponents of socialized medicine will have lost their appeal to the public.

Plans are progressing for the meeting in Charleston during the second week in May of 1955 and most of the out-of-state speakers have already been obtained. The Scientific Program Committee is doing an excellent job and the meeting should be one of the best.

Tom Gaines

ANNOUNCEMENTS

Invitation To All South Carolina Physicians To Attend

FOURTH ANNUAL MEETING SOUTH CAROLINA CHAPTER AMERICAN COLLEGE OF SURGEONS

Columbia Hotel

Columbia, South Carolina

Friday and Saturday—October 29th and 30th,
1954

Registration and "get-togethers" Thursday Evening
October 28th.

Ladies: Registration and Lounge Room—Columbia Hotel.

"Coffee" and Fashion Show — Friday,
October 29th, 11:30 A. M.

Banquet and Dance—Friday Evening,
October 29th.

Football Game—U. S. C. vs. Maryland—
Saturday Afternoon, October 30th.

PROGRAM

Friday, October 29th

8:30 A. M. Registration—Mezzanine, Columbia Hotel

Empire Room—Columbia Hotel

Presiding: Austin T. Moore, M. D., F.A.C.S.,
Columbia, S. C.

President S. C. Chapter American College of
Surgeons

9:15 A. M. Welcome—David F. Adcock, M.D.,
F.A.C.S., President Columbia Medical Society

9:20 A. M. "A New Technique in Varicose Veins
Surgery"

Richard S. Wilson, M. D., Spartanburg, S. C.

9:40 A. M. "Use of Sutures in Cataract Extrac-
tion"

David S. Asbill, M.D., F.A.C.S., Columbia,
S. C.

10:00 A. M. "The Present Status of the Surgical
Treatment of Lesions of the Stomach"

William F. Rienhoff, Jr., M.D., F.A.C.S., Associate Professor of Surgery, Johns Hopkins Hospital, Baltimore, Maryland.

10:45 A. M. "Abdominal Pregnancy"

Heyward H. Fouché, M.D., F.A.C.S., Columbia, S. C.

11:05 A. M. "The Vaginal Approach To Pelvic
Pathology"

F. Bayard Carter, M.D., Professor of Obstetrics and Gynecology, Duke University Hospital, Durham, North Carolina

11:50 A. M.—"Some Experiences with Surgery of
Intracranial Aneurysms"

William H. Bridgers, M.D., F.A.C.S., Columbia, S. C.

12:10 A. M. "Subarachnoid Alcohol and Other
Types of Block for Relief of Pain in Advanced Cancer"

John M. Brown, M.D., Charleston, S. C.
Jennings K. Owens, M.D., Bennettsville, S. C.
Frederick E. Kredel, M.D., F.A.C.S., Charleston, S. C.

12:30 A. M. Adjournment for lunch.

1:00 P. M. Luncheon and Business Meeting—
Fellows of the American College of Surgeons,
State Room, Columbia Hotel

Guest Speakers:

Peter B. Wright, M.D., F.A.C.S., Professor of Orthopedic Surgery, Georgia Medical College, Augusta, Ga., Governor Southeast District, American College of Surgeons.

David Henry Poer, M. D., F.A.C.S., Associate Professor of Surgery, Emory University Medical College, Atlanta, Ga., Past Governor American College of Surgeons

2:30 P. M. "Controversial Points in the Diagnosis and Treatment of Lesions of the Skeletal System"

Bradley L. Coley, M.D., F.A.C.S., Attending Surgeon in Charge of Bone Tumor Department, Memorial Hospital for Treatment of Cancer and Allied Diseases, New York City

3:15 P. M. Panel Discussion: "Diseases of the Thyroid Gland"

William H. Prioleau, M.D., F.A.C.S., Charleston, S. C.—Moderator

William F. Rienhoff, M.D., F.A.C.S., Johns Hopkins—Guest Surgical Panel Member

O. B. Mayer, M.D., F.A.C.P., Columbia, S. C.—Guest Medical Panel Member

John C. Hawk, M. D., F.A.C.S., Charleston, S. C.—Surgeon in Charge Isotope Laboratory, Medical College of South Carolina

3:15 P. M. Panel Discussion: "Obstetrics and Gynecology" F. Bayard Carter, M. D., Professor of Obstetrics and Gynecology, Duke Univ. Hospital, Durham, North Carolina

4:15 P. M. Panel Discussion: "Bone Tumors"

Austin T. Moore, M.D., F.A.C.S., Columbia, S. C.—Moderator

Bradley L. Coley, M. D., F.A.C.S., New York City—Guest Surgical Panel Member

Oscar L. Miller, M.D., F.A.C.S., Charlotte, N. C.—Guest Orthopedic Panel Member

Henry Potosky, M.D., Chief of Radiology, Vet. Adm. Hospital, Columbia, S. C.—Guest Radiological Panel Member

Henry A. Plowden, M.D., Pathologist Columbia Hospital Columbia, S. C.—Guest Pathologist Panel Member

5:15 P. M.—Adjournment

7:30 P. M.—Cocktails—

Empire Room, Columbia Hotel (Black tie preferred—Ladies invited)

8:00 P. M.—Banquet—

Greetings: Thomas R. Gaines, M.D., F.A.C.S., —President South Carolina Medical Association

Speaker: Dr. Donald Russell — President University of South Carolina

Dance—Special Entertainment

Saturday, October 30th

8:00 A. M.—Operative Clinics:

Columbia Hospital, S. C. Baptist Hospital, Providence Hospital

9:30 A. M. Empire Room—Columbia Hotel

"Acute Calcific Tendonitis"

John A. Siegling, M.D., F.A.C.S., Charleston, S. C.

9:50 A. M. "Diagnosis of Kidney Tumors"

Wallace D. Cone, M. D., Sumter, S. C.

10:10 A. M. "Side Actions of Anesthetic Agents"

Lester Rumble, Jr., M.D., Director of Anesthesiology, St. Joseph's Infirmary, Atlanta, Ga.

10:40 A. M. Panel Discussion: "The Treatment of The Burned Patient"

Auspices of American College of Surgeons—S. C. Chapter, Committee on Trauma

Lawrence H. McCalla, M.D., F.A.C.S., Greenville, S. C.

Chairman of the South Carolina Committee on Trauma—Moderator

Cecil G. White, M.D., F.A.C.S., Greenville, S. C.

Robert F. Hargarty, M.D., Charleston, S. C.

11:40 A. M. Adjournment

2:00 P. M. Football Game U.S.C. Vs. Maryland
—Special Reserved section on 50 yard line for
Doctors attending meeting.

(Tickets may be secured by writing directly to
The University of South Carolina)

TRIBUTE TO DR. WILLIAM ATMAR SMITH

At the meeting of the Charleston County Medical Society on November 9, 1954 at 8 P. M., a bronze plaque with a profile of Dr. William Atmar Smith, former President of the South Carolina Medical Association, will be presented to Pinchaven Sanatorium. This plaque has been made possible by funds contributed by Dr. Smith's medical friends. The sculpture is by Willard Hirsch of Charleston.

The medical friends of Dr. Smith are invited to attend.

THE MONTH IN WASHINGTON

Washington, D. C.—When the 84th Congress convenes in January, the Eisenhower Administration will press for passage of at least two bills that failed to get through last session, reinsurance and a new program of medical care for military dependents. The former was decisively defeated in the House. The latter did not reach a vote in either chamber.

In a radio address summing up his Administration's legislative achievements, Mr. Eisenhower confirmed that he was prepared to renew the fight next session to have the federal government set up a system for reinsuring health insurance programs. He declared: "Health reinsurance we are going to put before Congress again because we must have a means open to every American family so that they can insure themselves cheaply against the possibility of catastrophe in the medical line."

There have been no indications how far the Administration would go in amending the reinsurance bill to satisfy its critics. It is possible also that if all objectionable features were removed there would be little left of the bill.

At Senate and House hearings, reinsurance was roundly denounced by most witnesses, for a variety of reasons. AMA's position was that reinsurance wasn't needed because private funds are available for the limited amount of reinsurance that could be used, and that in addition the program projected the federal government too far in the direction of control of medical care.

Later in the session, Mr. Eisenhower himself and Mrs. Hobby made every effort to win over critics of reinsurance, and to force the bill through Congress. In the light of these efforts—including a nationwide radio appeal by Mrs. Hobby—the defeat of the bill in the House of Representatives was regarded as one of the most surprising suffered by the Administration on any domestic legislation.

Currently Secretary Hobby and Chairman Charles Wolverton of the House Interstate and Foreign Commerce Committee are attempting to bring together all parties interested in health legislation to see if a compromise can be worked out on reinsurance.

Although the dependent medical care bill wasn't passed, this fact was not in any way regarded as a defeat for Mr. Eisenhower. The bill was offered in the Senate in plenty of time for action, but the introduction of the House bill was held up until Defense Department could estimate the first year's cost, eventually set at \$67 million. At any rate, neither Senate nor House Armed Services Committee held hearings on the measure.

In another statement, Mr. Eisenhower made it clear that he expects the next Congress to do something about improving and making more uniform the system of medical care for servicemen's families. Congress, he said, "must eventually meet certain imperative needs of the members of the armed forces." He explained that servicemen now "lack adequate medical care for dependents . . . It is most important that these needs of the armed forces personnel serving their country often in remote corners of the world engage our serious consideration."

Although the American Medical Association has not had an opportunity to testify on the dependent care plan before Congressional committees, it has made its views known to the Defense Department. In general the AMA is not opposed to Defense Department proposals that a more uniform system be worked out, and that the federal government bear most of the cost. On one important point, however, the recommendations of the department and of the Association are in direct conflict: The department would have the military medical departments themselves furnish dependent medical care wherever they could, with service families going to private physicians and private hospitals only where the uniformed physicians couldn't handle them. The Association, on the other hand, proposes that dependents be cared for by the military departments only where civilian medical facilities are inadequate to furnish proper care.

Federal officials, meanwhile, are busy preparing to put into effect the new health bills passed by Congress. Basic state allotment percentages have been worked out for the new Hill-Burton program (for facilities other than complete hospitals) and for the expanded vocational rehabilitation program. The Internal Revenue Bureau is about to issue detailed instructions to taxpayers regarding changes in medical expense deductions and other benefits in the new tax law.

—AMA Washington Office

The largest and most widely instructive meeting of surgeons in the world, the 40th annual Clinical Congress of the American College of Surgeons, will be held in Atlantic City, New Jersey, November 15 to 19. More than 10,000 Fellows of the College and their guests from all over the world will gather to fulfill the purposes of this Congress: to discover, to inform and to learn. This postgraduate education meeting will present recent surgical developments through a wide variety of programs, including panel discussions, symposia, surgical forums, motion pictures, cine clinics, color television and exhibits. Dr. Charles deT. Shivers, Atlantic City, is Chairman of the Atlantic City Advisory Committee on Arrangements.

Dr. Frank Glenn, New York, current President of the American College of Surgeons, will preside at the opening evening session, at which Dr. Alan Gregg, New York, and Dr. Robert H. Kennedy, New York, will be guest speakers. On the final evening Dr. Alfred Blacklock, Baltimore, will be installed as President for the coming year.

Dr. Evarts A. Graham of St. Louis is Chairman of the Board of Regents and Dr. Paul R. Hawley of Chicago is The Director.

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

COUNTY OFFICERS—1954-55

ANDERSON

President: Mrs. James Belk, Old Greenville Highway, Anderson, S. C.
Vice-President: Mrs. Clyde Bowie, 2102 N. Main St., Anderson, S. C.
Secretary: Mrs. Leo Davison, 305 Boulevard, Anderson, S. C.
Treasurer: Mrs. J. R. Young, 504 Boulevard, Anderson, S. C.

CHARLESTON

President: Mrs. S. Edward Izard, 44 King St., Charleston, S. C.
President-Elect: Mrs. John T. Cuttino, James Island, S. C.
Vice-President: Mrs. J. Richard Sosnowski, 1½ McLeod Place, Charleston, S. C.
Secretary: Mrs. Henry C. Heins, The Creseent, Charleston, S. C.
Treasurer: Mrs. I. Ripon Wilson, Jr., 99 S. Battery, Charleston, S. C.

EDISTO

President: Mrs. James L. Wells, Club Acres, Orangeburg, S. C.
Vice-President: Mrs. Albert Wolfe, 740 N. Blvd., N. E., Orangeburg, S. C.
Secretary: Mrs. James Sheeut, 150 Lindale, S. W., Orangeburg, S. C.
Treasurer: Mrs. Harry L. Tuten, 351 Carolina, N. E., Orangeburg, S. C.

GREENVILLE

President: Mrs. John K. Webb, 140 W. Mountain View Ave., Greenville, S. C.
President-Elect: Mrs. McMurray Wilkins, 17 Spruce St., Greenville, S. C.
Vice-President: Mrs. Charlton Armstrong, Woodland Way, Greenville, S. C.
Recording Secretary: Mrs. W. S. Hawkins, 100 Tindal Ave., Greenville, S. C.
Treasurer: Mrs. Hayne Taylor, 206 McPherson Lane, Greenville, S. C.
Corresponding Secretary: Mrs. Hal Powe, Jr., 13 Victory Ave., Greenville, S. C.
Corresponding Secretary: Mrs. Lawson Stoneburner, Trails End, Greenville, S. C.
Parliamentarian: Mrs. David Wilson R.F.D. #5, Greenville, S. C.
Historian: Mrs. Richard M. Pollitzer, 13 University Ridge Apts., Greenville, S. C.

HORRY

President: Mrs. Wayne Reeser, 804 Burroughs St., Conway, S. C.
Vice-President: Mrs. W. K. Rogers, Loris, S. C.
Secretary: Mrs. C. L. Mattes, Box 1701, Myrtle Beach, S. C.
Treasurer: Mrs. R. L. Jackson, 905 Burroughs St., Conway, S. C.

KERSHAW

President: Mrs. Ripon LaRoche, Camden, S. C.
Vice-President: Mrs. Herbert Schreiber, Camden, S. C.
Secretary: Mrs. Harold Webb, Camden, S. C.
Treasurer: Mrs. Charles Vincent, Camden, S. C.
Corresponding Secretary: Mrs. Robert Watkins, Camden, S. C.
Historian: Mrs. Joe Brinson, Camden, S. C.

NEWBERRY

President: Mrs. R. E. Livingston, 2230 Main St., Newberry, S. C.
Vice-President: Mrs. E. G. Able, McCaughrin Ave., Newberry, S. C.
Secretary: Mrs. Von Long, McHardy St., Newberry, S. C.
Treasurer: Mrs. V. W. Rinehart, Mayer Ave., Newberry, S. C.
Historian: Mrs. A. W. Welling, Wells Drive, Newberry, S. C.

PEE DEE

President: Mrs. Wayne Reeser, Conway, S. C.
Vice-President: Mrs. James Allen, Irby St., Florence, S. C.
Secretary: Mrs. George Dawson, Greenway Drive, Florence, S. C.
Treasurer: Mrs. George Smith, Mohawk Drive, Florence, S. C.

PICKENS

President: Mrs. C. F. Higgins
Vice-President: Mrs. T. P. Valley
Treasurer: Mrs. W. B. Furman
Historian: Mrs. J. L. Valley

RICHLAND

President: Mrs. K. M. Lippert, Veterans Hospital, Columbia, S. C.
President-Elect: Mrs. George W. Smith, 4201 Sequoia Rd., Columbia, S. C.
Vice-President: Mrs. R. F. Haines, 2911 Trenholm Rd., Columbia, S. C.
Recording Secretary: Mrs. B. L. Freeman, 2016 Glenwood Rd., Columbia, S. C.
Treasurer: Mrs. J. T. Green, 742 Abelia Rd., Columbia, S. C.
Corresponding Secretary: Mrs. J. Cordon Seastrunk, 1707 Maplewood Dr., Columbia, S. C.

SPARTANBURG

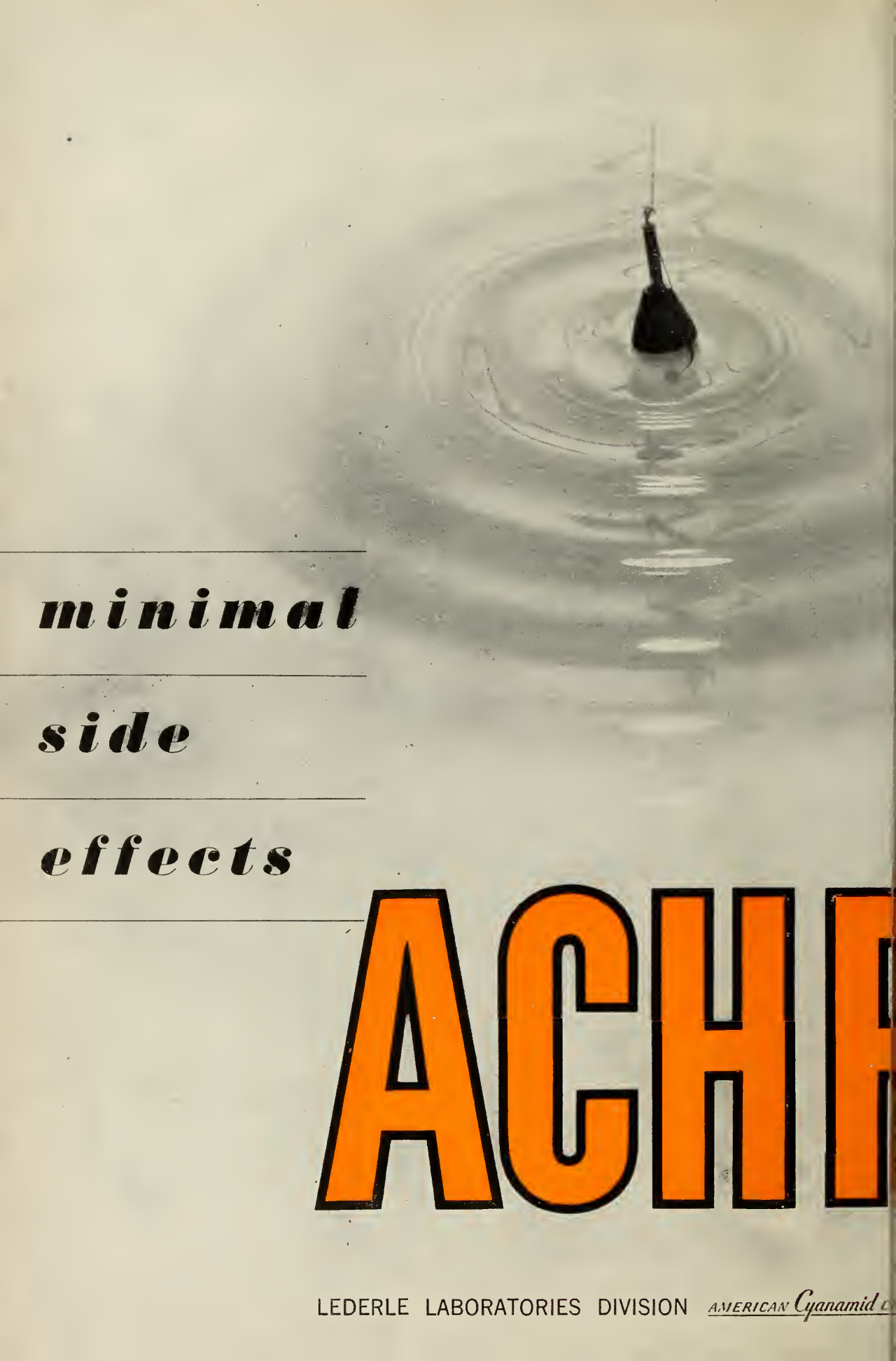
President: Mrs. J. C. Hedden, 388 S. Fairview Ave., Spartanburg, S. C.
President-Elect: Mrs. James Allgood, Inman, S. C.
Vice-President: Mrs. Paul Holcombe, 559 Poplar St., Spartanburg, S. C.
Secretary: Mrs. Fred Adams, 199 Converse Circle, Spartanburg, S. C.
Treasurer: Mrs. S. J. Morrow, Inman, S. C.

SUMTER

President: Mrs. James E. Bell, Jr., 252 Broad St., Sumter, S. C.
Vice-President: Mrs. Wallis Cone, Calhoun Drive, Sumter, S. C.
Secretary: Mrs. Wilson Creene, Jr., 110 Waetor St., Sumter, S. C.
Treasurer: Mrs. D. O. Winter, 331 N. Main St., Sumter, S. C.

YORK

President: Mrs. W. H. Williams, Jr., 616 Meadowbrook Lane, Rock Hill, S. C.
President-Elect: Mrs. Alton Brown, 904 Myrtle Dr., Rock Hill, S. C.
Vice-President: Mrs. J. Rufus Bratton, 619 Lucas St., Rock Hill, S. C.
Secretary: Mrs. Thomas A. Murrah, 975 Beverly Drive, Rock Hill, S. C.
Treasurer: Mrs. Roderick MacDonald, 325 College Ave., Rock Hill, S. C.



minimal

side

effects

ACH

LEDERLE LABORATORIES DIVISION *AMERICAN Cyanamid*

One of the notable qualities of ACHROMYCIN, the Lederle brand of Tetracycline, is its advantage of minimal side effects. Furthermore, this true broad-spectrum antibiotic is well-tolerated by all age groups.

In each of its various dosage forms, ACHROMYCIN provides more rapid diffusion for prompt control of infection. In solution, it is more soluble and more stable than certain other antibiotics.

ACHROMYCIN has proved effective against a wide variety of infections caused by gram-positive and gram-negative bacteria, rickettsia, and certain virus-like and protozoan organisms.

ACHROMYCIN ranks with the truly great therapeutic agents.

ACHROMYCIN

HYDROCHLORIDE
Tetracycline HCl Lederle



rl River, New York

Historian: Mrs. E. E. Herlong, Herlong Ave., Rock Hill, S. C.

GREENWOOD AND ABBEVILLE

President: Mrs. Albert Adams, 241 Jennings Ave., Greenwood, S. C.

Vice-President: Mrs. W. A. Klauber, 445 Durst Ave., Greenwood, S. C.

Secretary: Mrs. Hunter May, 1030 Edgefield St., Greenwood, S. C.

Treasurer: Mrs. Brooks Scurry, 352 Janeway, Greenwood, S. C.

OCONEE

President: Mrs. L. E. Mays, Seneca, S. C.

Vice-President: Mrs. Samuel Moyle, Walhalla, S. C.

Secretary: Mrs. Rufus K. Nimmons, Jr., Townville St., Seneca, S. C.

Treasurer: Mrs. W. H. Hunter, 102 Oak Terrace, Clemson, S. C.

PEE DEE AUXILIARY AWARDS THREE SCHOLARSHIPS TO STUDENT NURSES

Since the James McLeod Memorial Scholarship awarded annually by the Pee Dee Medical Auxiliary had not been used for three years the executive board decided to award three scholarships this fall. Recipients of this aid are Shirley Ganey of Rockingham, N. C., Jarma Jean Chewing of Manning and Beverly Ann Carter of Manning. These awards were based on scholastic record and financial need. All three girls are freshman students at the McLeod Infirmary School of Nursing. They were presented to a group of Auxiliary members at an informal Coca Cola party in the library of the McLeod Infirmary recently. The Auxiliary is indebted to Miss Rita Smith, director of nurses, and Mrs. Bertie Stokes, nurse recruiting officer for the hospital for their assistance in selecting worthy girls.

VFW AUXILIARY AWARDS NURSING SCHOLARSHIP

Miss Rachel Borkowitz of Scranton has been chosen by the Veteran of Foreign Wars Auxiliary for a full three-year term scholarship at McLeod Infirmary School of Nursing. Mrs. Hazel Wells, president of the Florence Auxiliary, made the presentation Tuesday, July 27, in the library of the hospital. Miss Borkowitz, a daughter of Mr. and Mrs. J. A. Borkowitz, graduated from Lake City High School. The admissions committee took into consideration for their judging of a list of possible candidates the worthiness of the case, scholastic rating and membership of a member of the immediate family in the U. S. Armed forces. Miss Borkowitz has a brother who is serving with the U. S. Nav., presently stationed in the Mediterranean.

"A FAMILY DOCTOR IN EVERY DOCTOR'S FAMILY"

This resolution was adopted at the annual convention of the Woman's Auxiliary to the American Medical Association and we reprint it here feeling that it is of vital interest to every doctor's wife.

WHEREAS, The health needs of the American people can adequately be met only if there is ample number of able and efficient practitioners of medicine, and

WHEREAS, The health of America's doctors is thus a matter of grave concern not only to the individual doctors, their families, and the entire medical profession, but to the public as well, and

WHEREAS, It is a well recognized and deplorable fact that the physician is often the last one to heed ad-

vice he urges upon his patients and thus often goes without periodic examinations or without the advantage of a personal physician who maintains an accurate health record of the individual physician and the members of his family, and

WHEREAS, Failure to heed his own advice, and failure to employ the services of a family physician for himself and his family may be directly related to the fact that the average expectancy of physicians in America is appreciably lower than the average expectancy of males generally, and

WHEREAS, The members of a physician's family are deprived of adequate and proper medical care if they resort to first one and then another of the physician's medical colleagues with no single individual filling the role of a personal physician for the family and maintaining a continuing health record for each member of the family and

WHEREAS, The American Academy of General Practice, at the instigation of its late vice-president, Dr. Merrill Shaw of Seattle, has launched a program to persuade every physician in America to select a regular family physician for himself and his family, and

WHEREAS, This program, which has attracted wide-spread attention in newspapers and popular magazines, is setting an important precedent for the lay public, which, if followed, will improve the nation's health and simultaneously the goodwill enjoyed by the Medical Profession, now, therefore, be it

RESOLVED, That the Woman's Auxiliary to the American Medical Association commends the American Academy of General Practice for its meritorious efforts in the furthering of this worthy project, and be it further

RESOLVED That the Woman's Auxiliary to the American Medical Association hereby endorses the Academy's project and urges every member of the American Medical Association to support the program and co-operate in it by taking upon himself the responsibility of designating a physician to serve as family physician for his family, thus setting a prime example of good health practice for his patients and the people of his community.

W.M.A. NEEDS IMMEDIATE FINANCIAL SUPPORT. Doctors who are members of the United States Committee of the World Medical Association now are receiving letters, citing the present financial plight of the W.M.A. and urging immediate financial support to build up a depleted treasury.

In an urgent appeal from Dr. Louis H. Bauer, secretary-treasurer of the U. S. Committee, members are being asked to talk about the W.M.A. to their friends and sign them up. The membership fee is only \$10.

"At the moment," Dr. Bauer said in a note to me, "we do not have sufficient funds either to handle the General Assembly or run the association for another year."

Since its founding in 1947, the W.M.A. has earned increased respect from international governmental organizations.

"But," as Dr. Bauer says, "there is a constantly growing tendency for decisions affecting all of medicine to be made at the international level. This tendency is a threat not

Roentgenographic pattern of colon mass propulsion:¹

- (1) Ascending colon filled.
- (2) Unsegmented mass propelled through transverse colon.
- (3) Propulsive force follows mass through descending colon.
- (4) Pelvic colon reservoir filled.



Reestablishing Bowel Reflexes with Metamucil[®]

Nervous fatigue, tension, injudicious diet, failure to establish regularity, too little exercise, excessive use of cathartics—all factors which contribute to constipation.²

Sufficient bulk and sufficient fluid form the basic rationale of treatment of constipation with Metamucil.

Metamucil (the mucilloid of *Plantago ovata*) produces a bland, smooth bulk when mixed with the intestinal contents. This bulk, through its mass alone, stimulates the peristaltic reflex and thus initiates the desire to evacuate, even in patients in whom postoperative hesitancy exists.

Factors Contributing to Chronic Constipation

Such gentle stimulation is of distinct advantage in reeducating and reestablishing those reflexes which control bowel evacuation. Many factors may pervert the normal reflexes, causing finally chronic constipation. Among them are: nervous fatigue and tension, improper intake of fluid, improper dietary habits, failure to respond to the call to stool, lack of physical exercise and abuse of the intestinal tract through excessive use of laxatives.²

Correction of constipation logically, therefore, lies in the suitable adjustment of these factors. The characteristics of Metamucil permit the correction of most of these factors: it provides bulk; it demands adequate intake of fluids (one glass with Metamucil powder, one glass

after each dose); it increases the physiologic demand to evacuate; and it does not establish a laxative "habit." Metamucil, in addition, is inert, and also nonirritating and nonallergenic.

Dosage Considerations

The average adult dose is one rounded teaspoonful of Metamucil powder in a glass of cool water, milk or fruit juice, followed by an additional glass of fluid if indicated.

Metamucil is the highly refined mucilloid of *Plantago ovata* (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 4, 8 and 16 ounces. Metamucil is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Best, C. H., and Taylor, N. B.: *The Physiological Basis of Medical Practice: A Text in Applied Physiology*, ed. 5, Baltimore, The Williams & Wilkins Company, 1950, pp. 579-583.

2. Bagen, J. A.: *A Method of Improving Function of the Bowel*, *Gastroenterology* 13:275 (Oct.) 1949.

only to the future of medicine itself, but to the rights and privileges of every practicing physician. One example is the current attempt of incompetent organizations to draft a Code of International Medical Law which would affect all physicians in peace as well as in war. The World Medical Association is the only international organization which can and does speak from the non-governmental standpoint and from the standpoint of free enterprise. However, it can only continue to defend your interests if it has adequate financial support."

Dr. Bauer explained that W.M.A. support from industry as a whole has decreased this year and the campaign to increase individual membership in the U. S. Committee "has not been as successful as we had hoped."

Consequently, he is asking doctors all over the country to join in a renewed membership campaign. Application blanks can be secured from Dr. Louis H. Bauer, World Medical Association, 345 East 46th Street, New York 17, N. Y.

In spite of the fact that this country is considered one of the most civilized nations in the world—it is still the victim of a conversational taboo—the toilet. And judging from a survey conducted in the interest of Jonny Mop, a deodorizing, thorough disposable toilet mop, it was found that the taboo also extended to a form of *blindness* where this area of housekeeping is concerned. Modern woman has taken advantage of every appliance that has been waved in front of her—and what she hasn't encountered in modern equipment she has developed herself . . . but in the matter of complete bathroom hygiene she has pursued the ostrich-in-the-sand view, according to the Jonny Mop survey. Women are apparently uneducated to the dangers of toilet germs in their own home—and while they use every precaution in public washrooms they are utterly unaware of the dangers lurking in their own bathroom . . . because they obviously don't care to pursue a subject for which they have no natural appetite.

Out of 141 homes visited, and these ranged from medium low income brackets where bathrooms are only common to the very high where they are acutely luxurious, each one of the housewives maintained that the bowl in her bathroom was cleansed daily and could be considered only a paragon of cleanliness.

At a glance this attitude seemed an accurate appraisal . . . but when the subject of the lip of the bowl (which protrudes some two or three inches and is seldom seen) was discussed with the lady of the house or the maid,

139 out of 141 confessed ignorance as to how to handle the problem it housed.

Underneath the lip or rim, streams the water which flushes waste material, and over the lip is the toilet seat. "Do you, Madam," the questioner asked, "ever clean under the lip"? 139 out of 141 answered "no". Most of them contended it didn't seem necessary. When the survey group lifted the seat and a mirror was held so that it reflected the condition underneath the lip, the sensitive ladies were aghast. In every case there was a three to five inch yellow band of discoloration.

When a prominent laboratory (Associated Analytical Laboratory) swabbed this area in various houses, the results were cogent. The laboratory technician rubbed a sterile cotton swab underneath the rim of the bowl. He then went over the identical area with a Jonny Mop, so created that it contacts every accessible area with a soapy sanded deodorizer and cleanser that whitens the rim as it discourages the bacteria . . . then by pressing a tiny button in the handle the detachable tissue that did the cleansing is flushed away. The laboratory technician then swabbed it with sterile cotton to ascertain the bacterial count before and after, and calculated the percent of reduction. In one home, in the mid-town Murray Hill section of New York City, the bacteria count over a 24 hour period at 37 degree Centigrade, before being Jonny Mopped, was 3,648,000. After use of the Jonny Mop the percentage reduction was 44.25%. In a home on the upper East Side by using the Jonny Mop, percent reduction was 17%. On the upper West Side the tests revealed a bacteria content of 162,000. The percent reduction ran to 92%.

The report commented that wiping an area of a toilet bowl with a Jonny Mop apparently reduced the numbers of the viable bacteria, and the samples taken were representative.

Only 6 of the 141 women interrogated suspected the possible presence of such dangerous odor-producing and health-hazard organisms as:

- Escherichia coli
- Aerobacter aerogenes
- Streptococcus faecalis hemolytic streptococci of Lancefield's Group D
- Micrococcus pyogenes var. albus
- Micrococcus pyogenes var. aureus
- Clostridium perfringens (gas gangrene)
- Clostridium putrificum
- Clostridium sporogenes
- Clostridium tetani (tetanus)
- Lactobacillus acidophilus
- Lactobacillus brevis
- Bacteroides sp. (have been found in mixed infections of the gastro-intestinal tract)

The Journal

of the

South Carolina Medical Association

VOLUME L

November, 1954

NUMBER 11

Emergency Treatment of Head Injuries

WILLIAM H. BRIDGERS, M.D., F.A.C.S.

Columbia, S. C.

The treatment of head injuries may be divided into three stages—first, routine evaluation and emergency care; second, close observation and intelligent nursing; and third, definitive neurosurgical operative treatment when indicated. The great majority of head injuries follow sudden deceleration or acceleration of the skull thus causing damage to the enclosed brain. The frequency of such injuries is apparent when one realizes the increasing number of automobiles and trucks on the highways along with the steady increase in speed and power. The purpose of this communication is to discuss a plan for immediate treatment as well as the interpretation of signs and symptoms of impending neurosurgical emergencies requiring definitive treatment.

When the patient is seen in the emergency room, the pulse, respirations and blood pressure should be taken immediately and recorded. Bleeding from lacerations can be controlled temporarily in most instances by simple compression bandages. If shock is present, as evidenced by a low blood pressure and rapid pulse, intravenous fluid consisting of glucose and saline should be started while the patient's blood is being cross-matched. The treatment of surgical shock takes precedence in head injury patients as with other types of injury. Persistent shock should cause careful search for reasons such as fractures of the extremities, fractured cervical spine or hemorrhage within the abdomen or thorax. Rarely, if ever, does shock occur from head injury alone. Certainly splinting of any extremity fractures should be done promptly.

Palpation of swollen areas in the scalp often gives one the false impression of a depressed fracture. This is due to the softened center of a subgaleal hematoma surrounded by firm edematous edges and cannot be relied upon as a sign of depressed skull fracture.

A rather complete physical examination is of even greater importance when the patient is unconscious and unable to indicate sites of pain or discomfort. The presence of only diaphragmatic breathing or an externally rotated lower extremity may point to a fracture dislocation of the cervical spine; palpation of the thorax may reveal subcutaneous emphysema as tell-tale evidence of a fractured rib and probable pneumothorax. A brief look in an unconscious patient's mouth may reveal broken dentures, dirt, gravel, or other foreign bodies. I recall seeing an unconscious patient some 24 hours after injury and found a large wad of tobacco in his pharynx. Swelling and discoloration over the spine may indicate a fracture with possible cord injury; bleeding from the ear is very suggestive of a basal skull fracture.

A brief and rather simple neurological examination often suffices in an unconscious patient; of importance would be the ability of the patient to move each of his extremities when stimulated; the comparative size and reaction of the pupils; the ability to feel a pinprick as evidenced by his moving his extremities when stimulated; the comparison of reflexes, and the patient's ability to cough or swallow. It must be recalled, however, that many of these signs may be absent while the patient is comatose. If the patient is responsive, as complete a neurological examina-

tion as possible should be done including an ophthalmoscopic and otoscopic examination for present information as well as for future reference.

A convulsion shortly after injury suggests contusion or laceration of the brain. No special treatment is indicated unless further attacks occur and then proper anticonvulsant measures should be instituted, such as the regulation of attacks with sodium phenobarbital or paraldehyde. Attacks of decerebrate rigidity consisting of a sudden extension and internal rotation of the extremities is a grave sign often indicating brain stem damage. This is often due to pontine hemorrhage but may be a result of extreme increased intracranial pressure from intracerebral, epidural or subdural hemorrhage. Dilated and fixed pupils are also grave signs and often indicate a poor prognosis.

Not infrequently while the examination is being done, suction is necessary because of the patient's inability to swallow or cough up blood, mucus or vomitus. I have found suction best carried out by the insertion of a smooth tipped catheter, containing 2 or more holes near the tip, into the nostril and gentle rotation of the catheter until it is well in the nasopharynx. After the nasopharynx is cleaned out, oxygen by nasal catheter (about 7 liters per minute) may be of benefit. An open airway is often essential in view of the partial obstruction due to a limp tongue or nasopharyngeal edema. Tracheotomy may be a life-saving procedure. I have seen dramatic changes in a patient's condition take place almost as soon as a tracheotomy tube was inserted. It is wise to order the hands of such patients restrained after the tracheotomy is done to prevent them from removing the tube.

Information as to the type of accident can be of considerable help. An unconscious patient resulting from a head-on automobile collision at high speed is far more apt to have a severe brain contusion than a simple concussion. A gunshot wound of the brain resulting from a bullet fired at close range is far more serious than one fired from a greater distance. If the patient is conscious, he may be able to relate what he last recalled before the injury and what he recalled afterward, there-

by giving some index as to the extent of his amnesia. The period of amnesia is definitely related to the extent of brain damage. It is well known that a serious brain injury can occur without the patient having a loss of consciousness. I have seen this on a number of occasions.

The presence of a lucid interval following a head injury, where a patient is dazed, recovers consciousness, and later becomes drowsy and comatose, is strongly suggestive of intracranial hemorrhage such as an epidural or intracerebral hemorrhage; however, it has been reported that less than 25% of such cases showing the lucid interval syndrome were actually due to hemorrhage. Children, shortly after having cerebral concussion, often show intermittent drowsiness, headache and vomiting for several hours after injury followed by complete recovery. Persistence of such symptoms, however, should be looked upon as probably being caused by intracranial hemorrhage until disproven.

X-rays of the skull are advisable unless the patient is in shock, exceedingly restless, or very critically injured. I do not think it wise to rush an extremely restless patient into the x-ray department to obtain unsatisfactory films; however, in most instances, particularly if the patient is unconscious, x-rays of the skull, and on occasions the cervical spine, may reveal important information. Certainly gunshot wounds, other penetrating wounds and compound injuries should be x-rayed if at all practical so that definitive treatment can be instituted. A linear fracture extending into the pneumatic sinuses or mastoid cells would necessitate antibiotics as a prophylactic measure against the possibility of meningitis. Similar therapy is indicated if the patient shows cerebrospinal fluid drainage from the nose or ear or has bleeding from an ear.

After x-rays have been made it is wise to take care of any scalp laceration which is present. This can be done as a rule by cleaning up an area around the wound after shaving a wide margin and injecting a local anesthetic in a circular fashion but not in the wound itself. This can be followed by very thorough cleansing, debridement and suture of the wound; if there are jagged and contused

edges, excision of such edges would be advisable. The incidence of infected scalp wounds is far higher than need be and the possible complications are extremely serious due to the direct venous channels connecting scalp and brain. Much definitive work can be done easily while the patient is unconscious provided he is not in shock. Tetanus antitoxin or toxoid and antibiotics should be given early.

If other injuries necessitate surgery, the choice of an anesthetic requires some consideration. Most often I have found sodium pentothal and regional anesthesia to be satisfactory in preventing pain and restlessness and not increasing intracranial pressure. In the presence of facial, mouth or neck injuries associated with edema, endotracheal anesthesia is probably advisable. Minor injuries or more marked extremity wounds in a co-operative patient can be handled well with regional anesthesia.

If the patient does not have an injury requiring immediate neurosurgery, such as a gunshot wound or compound depressed fracture, he should be admitted for careful observation. This is carried out by frequent check of the pulse, respirations, blood pressure, temperature and state of consciousness. A persistent decrease in the pulse and respiratory rate below normal often indicates increased intracranial pressure, possibly due to hemorrhage. A high temperature such as 103° or above shortly after brain injury is a serious sign. Hyperthermia is treated by exposure of most of the body surface, the use of alcohol sponges, ice packs, rectal aspirin, and if necessary ice water enema.

Early lumbar puncture, in my opinion, should be done mainly when it is believed it will give information which would alter the treatment. Often the patients are restless and unable to co-operate; consequently, the intraspinal pressure is increased so that a true pressure reading is not obtained. The presence of blood in the spinal fluid would indicate a traumatic subarachnoid hemorrhage and this would be the most important information gained by early lumbar puncture. A spinal tap after 24 or 48 hours in a serious head injury patient with increased intracranial pressure could be a very dangerous procedure in view

of the possible formation of a pressure cone causing medullary failure. If a spinal puncture is done, the pressure should be measured with a manometer since this is the only way the pressure can be correctly determined. The patient should be lying on his side with his head in a neutral position and not flexed. The legs should be flexed at right angles at the hips with a pillow between the knees. I have often demonstrated a rise in cerebrospinal fluid pressure from normal up to 300 millimeters of water by having the patient's head flexed while the spinal needle and manometer are in place.

Medication for pain such as aspirin or "APC" can be used; however, stronger medication such as codeine or Demerol should not be given unless the pulse, respirations, blood pressure and state of consciousness are satisfactory. I prefer to be called in order to give a "stat" order rather than give this responsibility to the nurses when a patient is being closely observed for signs of cerebral compression. Morphine should not be used because of its medullary depressant effect.

Extreme restlessness must be controlled to prevent the danger of exhaustion as well as further increased intracranial pressure. Again if the vital signs are satisfactory sodium phenobarbital or paraldehyde serve the purpose quite well. It is important to realize, however, that a gradual appearance of restlessness is frequently one of the first signs of intracranial hemorrhage.

Early fluid intake is easily supplied by intravenous glucose and saline. I do not feel that extreme dehydration is advisable. Certainly in warm weather replacement of water and salt should be considered. Ordinarily, 1000 ccs. of 10% glucose in saline twice a day is sufficient during the first two days if necessary. Blood, of course, is used if needed because of shock or a low hemoglobin.

I have found it very beneficial to the patient to begin tube feedings within 2 or 3 days after injury if he is still unable to take nourishment by mouth. Prior to this time he would have been receiving intravenous fluids. A small Levine tube such as a #12 can easily be inserted into the stomach by way of the nose, causing little, if any, discomfort to the patient.

Thereafter, tube feedings usually containing 1 calorie per cc., as well as water, vitamins, iron, laxatives, sedation or anticonvulsant medications can be given with ease.

Hand restraints may be necessary in a very restless patient. A very satisfactory restraint which I have used consists of a cotton pad, such as an abdominal pad, firmly placed around the wrist or ankle and covered with 3 widths of 4 inch adhesive tape over the entire length of the pad. Several thicknesses of gauze bandage in lengths of about 4 feet may be attached to this cuff and tied to the bed or siderail.

The leakage of blood or spinal fluid into the ear canal usually ceases within several hours or a few days. Besides antibiotics no treatment is necessary other than changing gauze dressings used to absorb the drainage. The ear canal should not be irrigated or plugged with cotton.

Early cerebrospinal fluid rhinorrhea also requires antibiotics. If clear fluid is noted coming from the nostril, a specimen can be collected and tested quantitatively for the presence of sugar. If sugar is present, the fluid is cerebrospinal fluid since nasal secretions do not contain sugar. A persistent cerebrospinal fluid rhinorrhea may have to be corrected by a plastic repair of the tear in the dura if conservative treatment does not arrest it.

General signs or increased intracranial pressure, restlessness, photophobia, stiff neck, and elevated temperature may indicate a meningitis secondary to fracture into the pneumatic sinuses or a bleeding ear. I have seen this occur in a fulminating fashion within 24 hours after injury as well as several days or weeks after injury. Appropriate antibiotic therapy would follow.

If there is a steady change in the pulse, respirations, blood pressure or state of consciousness, the patient should be checked neurologically for evidence of weakness of one side of the face, arm, or leg or a change in the size of a pupil. Such signs would suggest possible intracerebral or extradural hemorrhage and appropriate neurosurgical intervention should be carried out promptly.

Symptoms of headache, personality changes, drowsiness, slowed pulse or slowed respira-

tions a few to several days after injury suggests a subdural hematoma which is often bilateral. Visual diagnosis by means of exploratory burr holes is often the safest course when such symptoms and signs appear.

Late symptoms of headaches, dizziness, nervousness, irritability, memory changes, and difficulty in concentration could be indicative of either a chronic subdural hematoma or a postconcussion syndrome and neurosurgical study and treatment should be instituted.

It is imperative that compound depressed fractures of the skull, gunshot wounds and stab wounds of the brain as well as craniofacial wounds should be treated by applying a sterile headdressing, treating shock and then transferring the patient where definitive neurosurgical treatment can be done promptly. Such patients can be transported as a rule with safety.

Ordinarily the uncomplicated head injury patient who has had cerebral concussion and possibly a linear fracture of the skull is allowed up early if he desires. On occasions this is delayed because of complaints of headache or dizziness.

Head injury patients who have shown signs of cerebral contusion, manifested by high temperature, possible spasticity of the extremities, increased pulse and respirations, prolonged loss of consciousness, etc., but with slow gradual improvement often should have study such as a pneumo-encephalogram in view of the possibility of a subdural hematoma or hydroma.

Gunshot wounds of the brain, with the exception of wounds received at close range such as in suicidal injuries, most often recover following early operation. I recall a series of 25 consecutive gunshot wounds of the brain which I operated on overseas in a brain center during World War II with no early or late mortality. The limited amount of neurological residual is often gratifying.

The operative treatment of traumatic intracranial hemorrhage including epidural, subdural and intracerebral hemorrhage is most often curative and also without neurological sequelae if the patient is operated upon before evidence of brain stem injury appears.

With intelligent nursing care of head injury

patients as well as careful observation regarding the signs of the various types of traumatic intracranial hemorrhage, along with early

transportation when necessary for neurosurgery, much can be accomplished in saving many victims of tragic accidents.

Physiological Principals of Some Orthopaedic Appliances

BARNEY L. FREEMAN, JR., M. D.

Columbia, S. C.

It is the purpose of this paper to discuss some of the physiological principles which are used in some orthopaedic appliances and to present several illustrative cases.

In 1892, Dr. Julius Wolff,¹ a German physician, advanced the theory that every change in the form and function of a bone, or in its function alone, is followed by certain definite changes in its internal architecture, and secondary alterations in its external conformation. Wolff could never reduce the observation to a mathematical accuracy; however, it has

been generally accepted that function determines form.

In a fundamental article in October, 1949, Eggers, Shindler, and Pomerat,² presented experimental evidence that physiological compression at a fracture site favorably influenced the healing process. He called this the contact compression force. The manner in which he studied this was quite interesting. He had the problem of finding living bone which was free from compression tension and muscular influences, yet which would be suitable for the

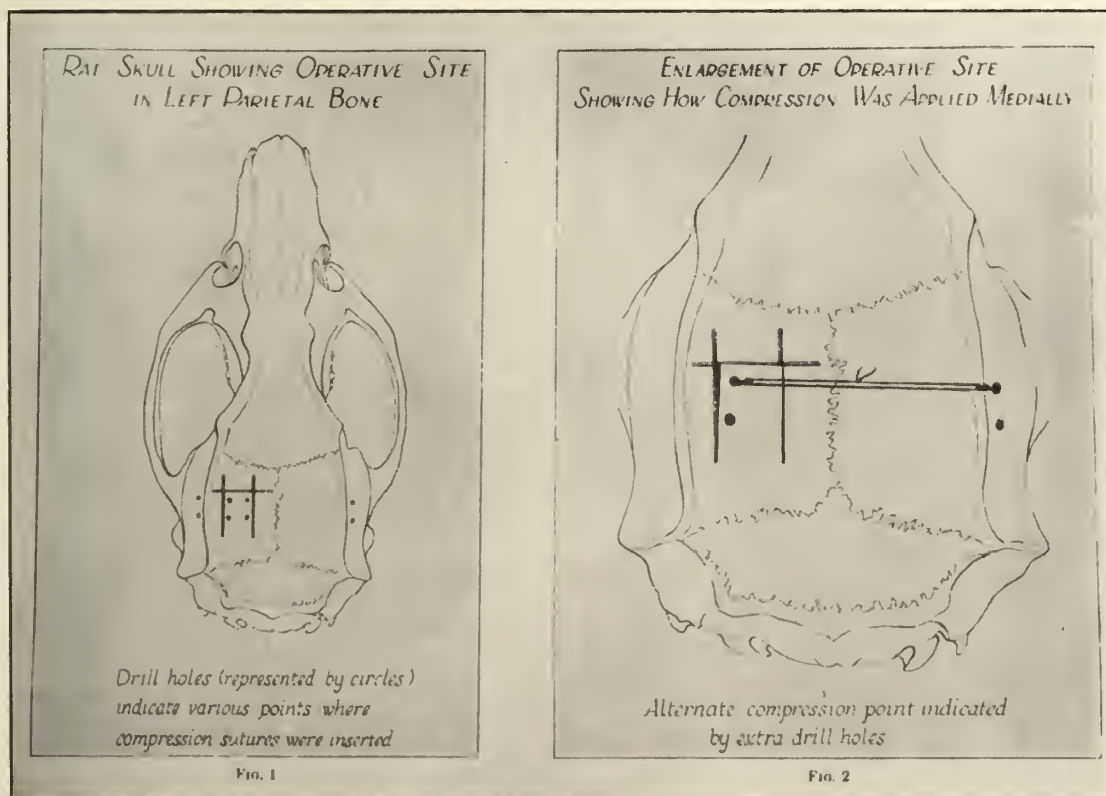


FIGURE 1

From The Moore Clinic.

application of controlled artificial force. The parietal bone of rats was decided upon.

Figure I illustrates the method used. As can be seen, a bone flap was fashioned in the skull, two holes were drilled into the flap, and compression applied to the flap with an elastic band, a small hook having been inserted into the drill holes in the skull.³ When serial microscopic sections were made, it was found that the areas subjected to the contact compression force showed osteogenesis at the end of 15 days. There was no osteogenesis in specimens which were not subjected to this force. It would seem, therefore, that some compression at fracture sites definitely increases osteogenic activity. It has further been found by Eggers, Shindler, and Pomerat² that too much force will actually cause necrosis and too little force fails to elicit any response. It would seem logical to assume that the optimum or physiological force for any given bone would probably be that force which that particular bone is normally required to take. This would be a combination of normal muscle pull and also perhaps body weight for that particular individual, body weight being pertinent in lower extremity fractures.

Not all fractures should be reduced openly and fixed internally, but when indicated, the internal fixative devices ideally should be sufficient to maintain rigid immobilization, if possible, without resorting to any external support. The contact compression force should be allowed to take place in addition to this strong rigid immobilization.

Some of the recent appliances which are widely used in orthopaedic and traumatic surgery which utilize the above principles are intramedullary nails and slotted plates, of which there are many different types.

Intramedullary fixation was first used in 1908 by Lambotte,⁴ who fixed internally a fractured clavicle with an intramedullary wire. Under the influence of Gerhard Küntscher,^{5 & 6} the Germans became very interested in the use of intramedullary nails, particularly in the femur. Küntscher began using these rather extensively in 1939. He did considerable experimental investigation on this particular subject. We noticed that some of our prisoners of war had been treated with intramedullary

nailing with excellent results. Since, then, there has been widespread interest in this type of fixation and it has now become a standard method for treating certain types of fractures. This method utilizes the contact compression force and also offers extremely firm fixation so that the patient can usually be made ambulatory. With weight bearing, the fragments can be pressed into constant apposition by the weight of the body in walking, and by muscle tone when resting. The fragments usually are not distracted because of this muscle tone, but rather constantly approximate each other since they can move up and down on the device without moving laterally or in an anteroposterior plane. The advantages of this type of treatment are both physical and economical. With rigid fixation which requires no external support, the complications of prolonged bed rest, joint stiffness, thrombophlebitis, osteoporosis of disuse, muscular atrophy, and others, can be prevented. The economical complication of prolonged hospitalization is also overcome. Certain types of femoral fractures are ideally suited for this method of treatment; however, some fractures of the tibia and other bones are also amenable to this type of fixation. Recently, it was felt by Vom Saal⁷ that perhaps the use of multiple nails would give more rigid fixation to the tibia.

Figure II shows x-rays of a compound femoral fracture in a sixteen year old boy who was hit by an automobile while riding a motor scooter. He also sustained a compound comminuted fracture of the left patella in the lower pole and a simple fracture of the right radius. The boy was carried immediately to surgery where, under general anaesthesia, thorough debridement of all wounds was carried out. A separate incision was made to expose the femoral fracture site, the fracture was anatomically reduced, and was fixed internally with an intramedullary nail. All wounds were closed extremely loosely to allow free drainage. Moore and Green⁸ consider this as being extremely important, along with thorough debridement, rigid fixation and antibiotics in the prevention of infection. The fracture of the patella was treated by excision of the fragments, debridement and loose closure of the wound. The radial fracture was treated by

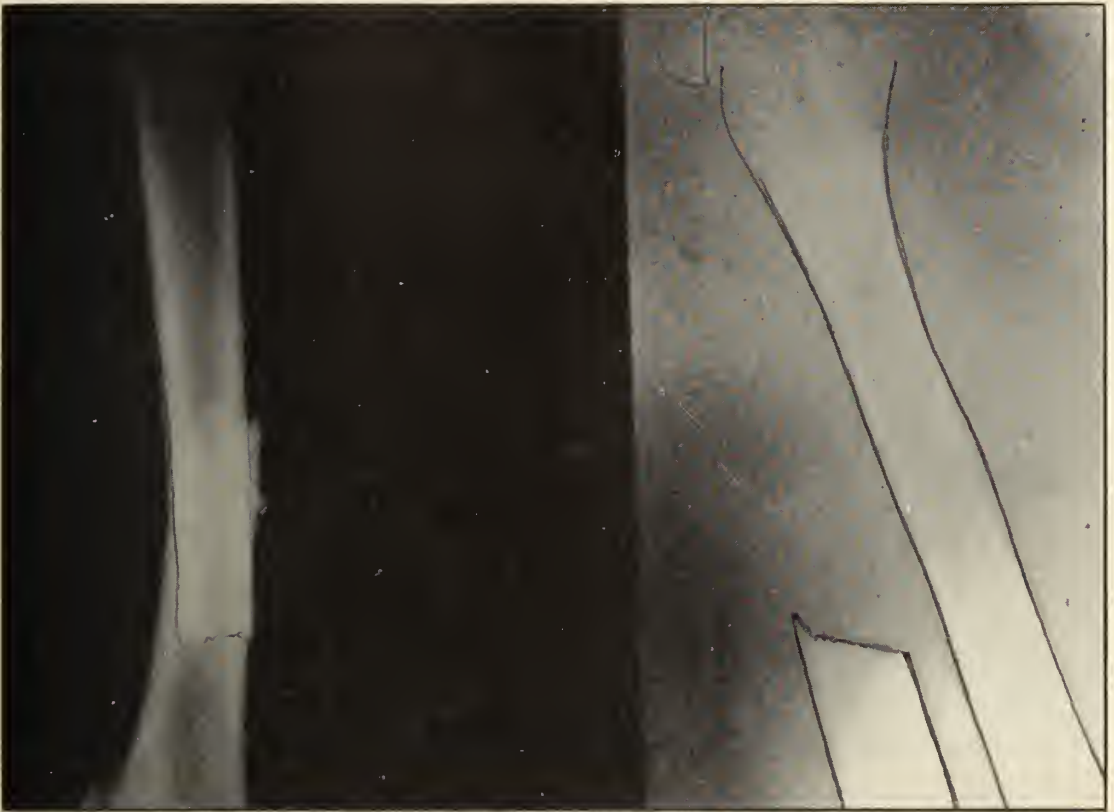
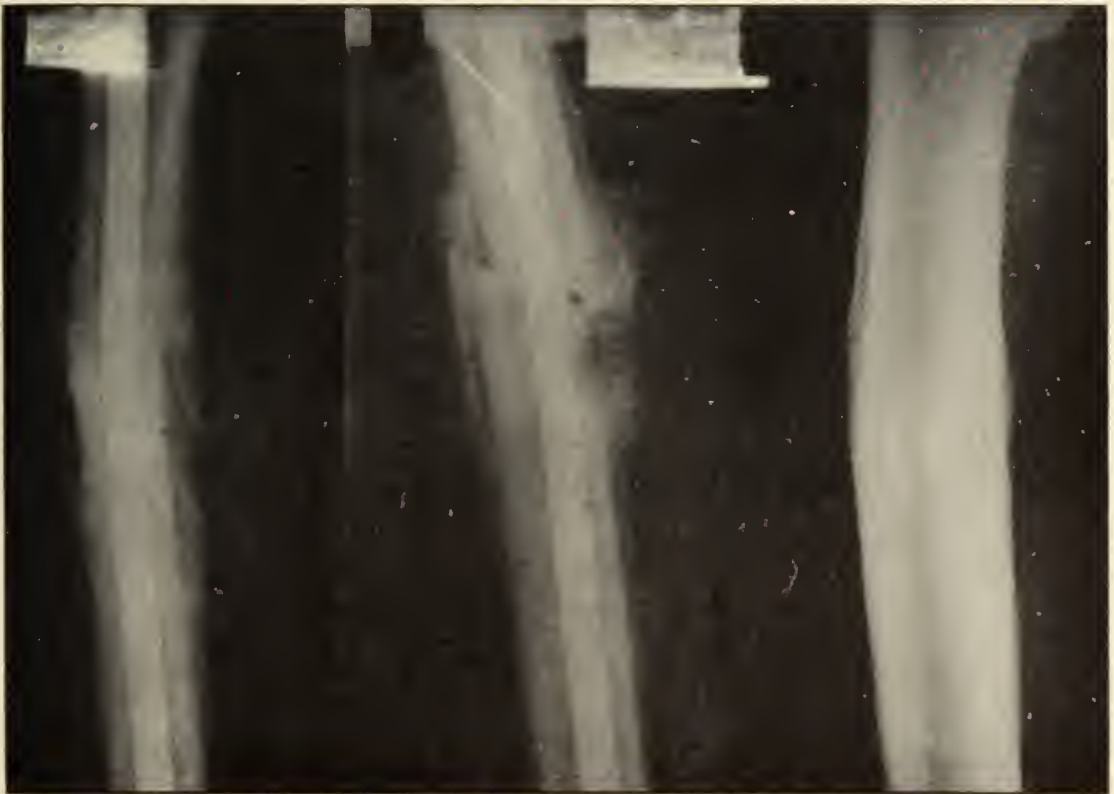


FIGURE II



6 Weeks

6 Weeks
FIGURE III

13 Months

closed reduction and application of a cast. This boy was ambulatory one week following surgery, and was dismissed from the hospital in 17 days, the wounds having healed per primam. This might be compared with treating the patient in traction, which would require several months of hospitalization, and if hip spica casting had been used, certainly several months of immobilization would have been necessary, with perhaps some temporary loss of motion of the joints and muscular atrophy on removal of the cast.

Figure III shows an x-ray of the femoral fracture six weeks following surgery, which illustrates well the advantages of the contact compression force. Thirteen months following the initial surgery, complete healing of the femur had occurred. The nail was simply removed, requiring only two days stay in the hospital. The femur was completely healed, as evidenced by x-ray following removal of the nail. See Figure III.

Figure IV illustrates a fracture of the tibia and fibula in a forty-five year old male who also sustained, in an automobile accident, dislocation of the right hip, fracture of the middle

third of the left humerus, compound fracture of a metacarpal of the left hand, fracture in the upper third of the right humerus, and almost complete avulsion of the right ear. Because of his condition on admission to the hospital, the patient was treated for shock, the dislocated hip was reduced, and the ear was sutured in place. Later, when his blood pressure had been stabilized and his general condition permitted, open reduction was performed on the left tibia and two interlocking intramedullary nails were used to fix the fracture internally. A bone graft from the ilium was placed about the fracture site at this operation.

Figure V shows the degree of healing present three months following surgery, the patient having been ambulatory three weeks post-operatively. This fracture has gone on to complete union. The patient walks with no support and the nails are to be removed in the near future.

Figure VI illustrates a segmental compound fracture of the tibia in a 44 year old male who was struck by an automobile. The fracture was treated by immediate surgery under spinal anaesthesia with thorough debridement of the



FIGURE IV



FIGURE V



FIGURE VI



FIGURE VII

wounds, application of a slotted plate to maintain the fragments in as good a position as possible, and loose closure of the wound.

Figure VII illustrates the reduction which was obtained and shows that the leg was immobilized in a long leg cast, this being allowed to remain on for two months, following which a short leg cast was applied for two months, then a brace. It is interesting to note that in applying the plates in this case, the screws in the proximal and distal fragments are placed in the ends of the slots away from the fracture sites, while the screws holding the center fragment were placed in the center of the slot. This was done so as to allow up-and-down movement of the fragments in any direction necessary so as to allow constant apposition of the fragments.

In Figure VIII one can see that the screws in the proximal and distal fragments are no longer at the ends of the slots but are in the center, thus denoting that the bone fragments have migrated upward and downward so as to allow constant apposition. This fracture has gone on to complete union without further

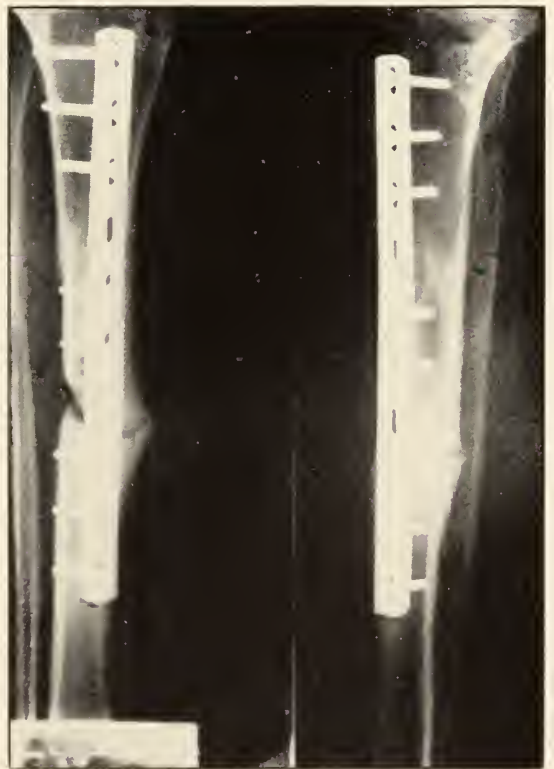


FIGURE VIII



FIGURE IX

treatment. It is feasible to assume that had this migrating action not occurred or if a regular type plate had been used, the screws could have actually held the fragments apart and, therefore, prevented union. Here again, the utilization of the contact compression force by a special type plate would appear to have materially aided union.

Figure IX shows the results of dual plating of a fracture of a femur in a twenty-four year old male who had a previous fracture of the femur, which can be clearly seen several inches above the plates. This previous fracture was treated with traction and casting for several months and complete bony union was obtained; however, the patient had a lengthy hospital stay and was left with considerable limitation of motion of the knee joint, which actually caused the fall producing this fracture. This patient had an additional problem in that his funds were completely depleted so that it was necessary to complete treatment and hospitalization as quickly as possible. Open reduction was performed. Dual plates were applied, the fracture being too low for

an intramedullary nail to be used. Intramedullary nailing also was precluded in this because of the previous fracture, there being deformity and no patent medullary cavity at the old fracture site. At the time of surgery, a bone graft from the ilium was placed about the fracture. Fixation was rigid. The wound healed per primam. The patient was ambulatory in two weeks and was dismissed from the hospital wearing a long brace in 27 days. The hospital stay was prolonged approximately 10 days while the brace was being completed. Actually, the large amount of metal which was used in this case is certainly not ideal, but it met the requirements of this case better than any other treatment at our disposal. This fracture went on to complete union, there having been no complications. The patient is now back at work. His brace has been discarded.

Many more examples could be cited in which right fixation and use of the contact compression force are utilized. The nailing operation using four Moore⁹ hip nails is very widely accepted as one of the best methods of treating fractured hips. It is not only an intramedullary type of fixation, but also employs to a certain extent the contact compression force. Screws in various forms have been largely discarded in the treatment of hip fractures since it has been found that with absorption of the femoral neck, the screws will definitely hold the fracture site apart.

Figure X illustrates the use of four Moore hip nails in treating a fracture of the neck of the femur.

Another condition in which the contact compression force is extremely advantageous is in fusions of the knee joint. To obtain union following surgical fusion of the knee joint, ordinarily a considerable period of immobilization is required. Key,¹⁰ Charnley,¹¹ Fett and Zorn,¹² and others have shown that fusion of the knee joint can be obtained much more rapidly when pins are placed in the bones above and below the joint following surgical destruction of the joint surface and application of definite compression applied to the bone edges.

This is not an advocacy to treat all fractures by open reduction and internal fixation, but is merely to present the physiological



FIGURE X

principles underlying some of the devices which are used in modern orthopaedic surgery.

SUMMARY

1. When open reduction and internal fixation of fractures are indicated, then fixation should be as rigid as possible.

2. Use of devices which employ rigid fixation and the contact compression principle appear to stimulate osteogenesis.

3. Intramedullary nails, slotted plates, and hip nails are examples of such devices.

4. Illustrative cases showing rigid internal fixation and employing the contact compression force are shown.

CONCLUSIONS

Rigid internal fixation of fractures when indicated and the employment of the contact compression principle appear to stimulate osteogenesis and hasten union. The complications of prolonged bed rest, immobilization, and hospitalization are minimized.

REFERENCES

1. Wolff, Julius. *Das Gesetz der Transformation der Knochen*. Berlin, A. Hirschwald, 1892.
2. Eggers, G. W. N.; Shindler, Thomas O.; and Pomerat, Charles M., *The Influence of the Contact-Compression Factor on Osteogenesis in Surgical Fractures*. *J. Bone & Joint Surg.*, 31-A, 693-716, 1949.
3. Reproduced from *Journal of Bone and Joint Surgery*, 31-A: 694, 1949.
4. Lambotte, Albin: *Chirurgie Opératoire des Fractures*. Paris, Masson et Cie, 1913.
5. Küntscher, Gerhard: *Die Marknagelung von Knochenbrüchen*. *Arch. f. Klin. Chir.*, 200: 443-455, 1940.
6. Küntscher, Gerhard, und Maatz, Richard: *Technik der Marknagelung*. Leipzig, Georg Thieme, 1945.
7. Vom Saal, Frederick: *Intramedullary Fixation of the Tibia*. *J. Bone & Joint Surg.*, 34-A: 86-95, 1953.
8. Moore, Austin T., and Green, James T., *Compound Fractures and Their Treatment*. *Southern Med. J.*: 32: 801-900, 1939.
9. Moore, Austin T., *Fracture of the Hip Joint. Treatment by Extra-Articular Fixation with Adjustable Nails*. *Surg., Gynec., & Obstet.*, 64: 420-436, 1937.
10. Key, J. A., *Positive Pressure in Arthrodesis for Tuberculosis of the Knee Joint*. *Southern Med. J.*, 25: 904-915, 1932.
11. Charnley, J. C., *Positive Pressure in Arthrodesis of the Knee Joint*. *J. Bone & Joint Surg.*, 30-B: 478-486, 1948.
12. Fett, H. C., and Zorn, E. L., *Compression Arthrodesis of the Knee*. *J. Bone & Joint Surg.*, 35-A: 172-177, 1953.

The Value of Exfoliative Cytology

WITH SPECIAL REFERENCE TO CARCINOMA OF LUNG AND CERVIX

H. R. PRATT-THOMAS, M. D.

Cytologic diagnosis may be defined in a semi-facetious way as the diagnosis of more and more from the study of less and less. This is at least a simple definition that may be remembered better than a more crude one.

In general cytologic diagnosis refers to the study of isolated cells and tissue particles as contrasted to biopsy in which a larger geographic representation of tissue structure is available. It should be emphasized that this definition in no way divorces cytology from the general field of pathology. Its practice does require some special knowledge and, above all, experience, but I do not believe in separating it from pathology, although there has been considerable effort expended in this direction. For this the pathologists themselves are in large part responsible. Anyone experienced in both fields knows that the division between cytology and tissue pathology is in large part an artificial one and strict separation between the two is not only difficult but unwise. The term "exfoliative" is only in part applicable, as in some locations, we have not waited for the cells to shed like autumn leaves, but have shaken the tree, as it were, to obtain their detachment by mechanical means. Examination of sputum for neoplastic cells is an example of exfoliative cytology in its pure and original form, whereas cervical smears are in general prepared by rubbing, scraping, or wiping the cells from the surface.

Probably the greatest controversy relative to this method has revolved about the fundamental criteria for a malignant neoplastic cell. It is still true that there are no absolute or infallible signs that declare a single isolated cell to be a malignant neoplastic one, but for every organ there is a normal cellular structure as well as one which has been modified by disease processes. Knowledge of the cellular response and variation to be expected under various conditions

makes it possible to know when cellular change has progressed beyond its physiologic limits and has become neoplastic.

Carcinoma of the lung is not only prevalent, but popular as a topic of scientific discourse. The diagnosis of this disease has been greatly advanced by the cytologic method, so that today a positive preoperative diagnosis may be made in approximately 50% more of the cases than was possible before study of sputum and bronchial washings became well established. This is due to the fact that in only from 25% to 30% of bronchogenic carcinomas can tissue be obtained by the bronchoscopist.

As in most fields there is a difference of opinion with regard to the value of this method. To illustrate this diversity we would like to quote from two recent authors. Ackerman¹ states: "By examination of sputum and/or bronchial washings it is now possible to make a diagnosis in about 80% of the cases while in operable carcinoma of the lung bronchoscopic biopsy is positive in only about one-third of the cases." R. A. Willis,² on the other hand, expresses the opinion: "Only a minority of tumors produce free clumps of tumor cells recognizable with certainty. The recognition of isolated tumor cells amongst the various non-neoplastic cells in sputum is difficult and the danger of false positive reports even by experts outweigh the value of the method." I do not agree with this statement and think that highly reliable results can be obtained from examination of sputum. That this opinion is shared by others experienced in this field is indicated by a recent statement in a communication from the Inter-Society Cytology Council³ regarding a forthcoming meeting: "The diagnostic accuracy in cancer of the cervix and lung is so well established that further verification at this meeting is not indicated." I prefer that the sputum be collected in formalin; specimens are then concentrated by centrifugation and the resultant semi-solid concentrate is treated like a piece of tissue and sections made and appropriately stained. We

From the Department of Pathology of the Medical College of South Carolina, Charleston, South Carolina.

have found that sections of sputum are more uniform and easier to handle than smears. It cannot be overemphasized that the material to be examined must be truly sputum and should be obtained by having the patient cough deeply and raise the representative sample from within the pulmonary tree. This examination has the advantage of enabling the patient to collect the specimens when sputum is most abundant and the examination may be repeated without the necessity of hospitalization. From three to five examinations are within the limits of practicality, and repeated specimens will increase the percentage of positivity. There is no advantage in the 24-hour specimen of sputum unless the amount being produced is very small. Daily specimens taken at times when sputum is most profuse or at different times on a single day when the sample seems to be a good one are all that is necessary. The results that may be expected from this procedure are presented in Table I. An early peripheral carcinoma diagnosed from sputum studies is shown in figure 1.

Table I—Results from Cytologic Study of 2,467 Specimens of Sputum and Bronchial Washings from 915 Patients with Pulmonary Disease.

161	Cases of Primary Carcinoma of Lung
118	Positive Cytological Diagnoses (73.29%)
16	Equivocal Diagnoses on Patients Proved to Have Carcinoma
	(11-Suspicious°)
	(5-Doubtful)
12	Equivocal Diagnoses on Patients Proved Not To Have Carcinoma
	(5-Suspicious)
	(7-Doubtful)
2	False Positives
	(1-Sputum 1-Pleural Fluid)
57.69%	of Primary Carcinoma Diagnosed by Cytologic Studies Only
83.23%	of Primary Carcinoma Diagnosed by Cytologic Studies and Biopsy

°Results are reported as carcinoma, suspicious, doubtful, or negative in pulmonary cytologic studies as well as in cervical smears. Suspicious and doubtful are indicative of gradations of abnormality.

Uterine cervical smears provide an excellent source for diagnosing asymptomatic early carcinoma. Such smears, when properly obtained, supply a comprehensive sampling of the cervical epithelium in which abnormal cells may be detected with a high degree of accuracy. There is often a controversy concerning

whether or not smears are better than biopsy or vice versa. This is unfortunate as the two are not designed to be competitive but complementary. In general, a localized or distinctive lesion of the cervix should be examined by means of biopsy. Normal cervixes or those which are mildly inflamed or eroded can, of course, also be examined by biopsy. True cellular representation requires that an around-the-clock biopsy procedure be employed, while in general, a cervical smear from the apparently innocent cervix supplies a rapid and simple technique which is available to all practitioners.

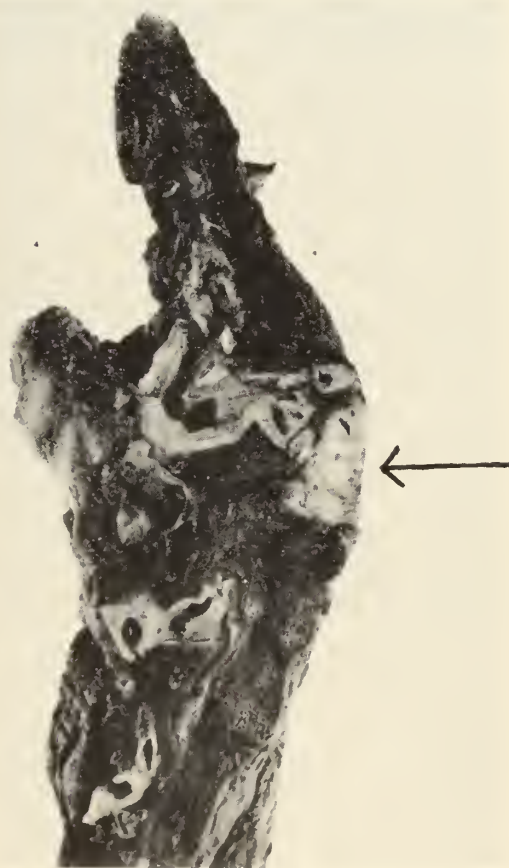


Figure 1

Small peripheral carcinoma of the lung in a man who had worked for years in a tuberculosis sanatorium. Diagnosis established by sputum studies.

The diagnosis of pre-invasive or intra-epithelial carcinoma is an extremely important matter in cancer control, as the tissue relationships are still maintained and metastases are not possible until the cellular relationships are disrupted (Figures 2, 3, 4, 5).



Figure 2

Uterine cervix showing the cellular changes of intra-epithelial carcinoma. A gland, indicated by arrow, is filled with atypical epithelium, but there is no invasion.

Results obtained in cervical smears from a consecutive series of one thousand patients taken from a group of 10,500 are given in Tables II and III. Probably the most important fact to be obtained from these statistics is that eight cases of early unsuspected cervical carcinoma were found in these one thousand women.

Table II—Analysis of Results of Smears in 1000 Consecutive Patients From a Series of 10,500 Cervical Smears.

Diagnosis of Carcinoma Cells	14
Diagnosis of Suspicious Cells	12
Total	26

Of the 14 Patients with Diagnosis of Carcinoma Cells, 13 proved to have Carcinoma

(No Follow-Up on One Case)

Of the 12 Patients with Diagnosis of Suspicious Cells, 8 were proven to have Carcinoma

2 were proven to have Epithelial Hyperplasia

1 was apparently negative

1 had no Follow-Up

Table III—More Detailed Analysis of the 26 Cases Having Abnormal Cervical Smears.

8 Cases—Routine Smears from Patients with Essentially Normal Cervices

(4 Diagnosed as carcinoma cells and 4 diagnosed as suspicious cells in smears. All proved to be intra-epithelial carcinoma on biopsy.)

8 Cases—Carcinoma Suspected Clinically

(7 Diagnosed as carcinoma cells and 1 as suspicious on smears. All had carcinoma on biopsy.)

5 Cases—Follow-Up Smears on Routine Cases Previously Positive Cytologically
(All 5 positive on biopsy.)

2 Cases—No Follow-Up

(One diagnosed as having carcinoma cells and 1 as having suspicious cells in smears.)

3 Cases—Epithelial Hyperplasia on Biopsy

(Reported as having suspicious cells in smears.)

TOTAL 26 CASES

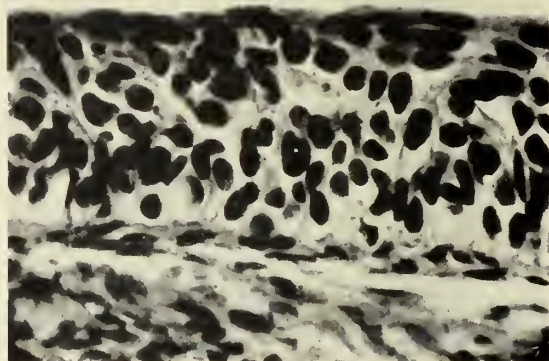


Figure 3

Cellular derangement and nuclear abnormality with hyperchromatism in surface epithelium of intra-epithelial carcinoma.

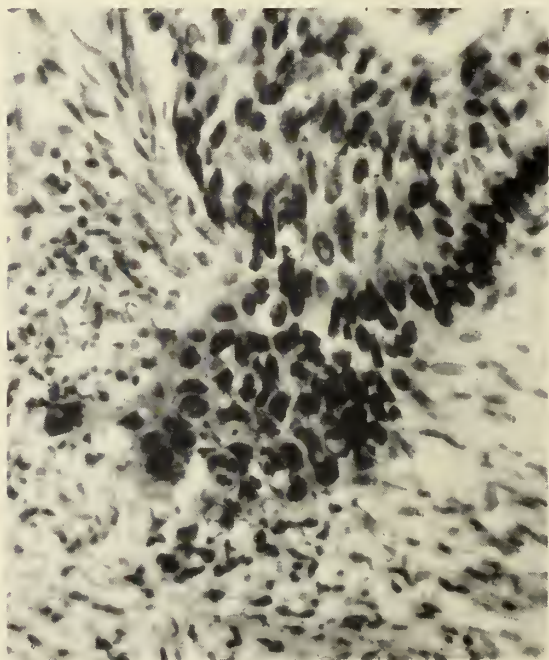


Figure 4

Neoplastic epithelial cells breaking through base of gland in early carcinoma.

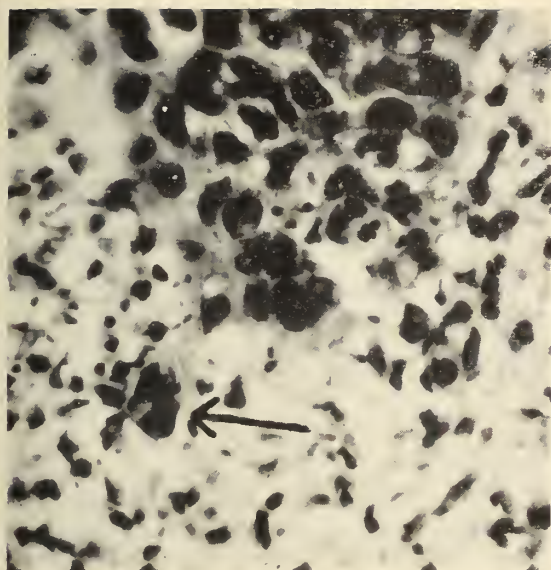


Figure 5

Neoplastic cells which are beginning to invade stroma from a focus of intra-epithelial carcinoma. This can progress to overt invasive carcinoma and set the stage for metastases.

The diagnosis of endometrial carcinoma by the smear technique is disappointing. A woman who continues to have abnormal bleeding after successive negative cervical smears, should be investigated by the usual surgical procedures. It is extremely unlikely that she will have carcinoma of the cervix, but she may still have endometrial carcinoma.

The cytologic method finds its most important application in relation to carcinoma of the lung and early carcinoma of the cervix. In the former disease it is possible to make a definitive diagnosis before an exploratory thoracotomy is required. In the latter, it offers a method of diagnosis when carcinoma is still definitely curative. The other forms of cytologic study have, at the present time, certain drawbacks, either philosophical or technical. Neoplastic cells can be diagnosed in pleural and ascitic fluid with a high degree of accuracy and are, of course, important; but the prognostic implication in positive reports in such cases is very dismal. Such a diagnosis is made with despondency rather than with the exhilaration which, I am frank to admit, follows the diagnosis of an early cervical carcinoma or even proof of a bronchogenic carcinoma.

Gastric cancer is probably one of the most challenging diseases within the entire diag-

nostic field. This is true, not only because of its prevalence, but also because of the dismal cure rates and five-year-survival rates at this time. Although the radiologist shows great skill and a remarkably high percentage of accurate interpretations, it still remains true that the only positive proof of carcinoma is to be had from a biopsy or cellular sample. If a simple and reliable method of cellular diagnosis could be devised, the controversy between internists and surgeons which at times assumes the proportions of internecine warfare would be abated. There are four current methods of obtaining cytologic material from the stomach in order to make a reliable diagnosis prior to an exploratory operation. At the present time, all of these fail in one if not two qualifications. They are not sufficiently simple to be universally employed, and the degree of accuracy is not sufficient to establish confidence. The stomach in its fasting state may be simply aspirated and washed with saline solution, or chemical or mechanical methods may be employed to accomplish the detachment of an adequate cellular sample. Papain has been the chemical agent utilized to produce active mucolysis with dissolution of the mucus coating within the stomach and resultant release of trapped cells.

Mechanical means are best exemplified by the gastric balloon and by the stomach brush. The instruments are somewhat formidable, and papain mucolysis presents several technical problems which remove these procedures from practical use in any place other than a special clinic or large hospital. We have diagnosed some carcinomas by this method, but admittedly, the majority of them left little clinical or radiologic doubt. We have missed a good many which should have been easily diagnosed, as they could be clinically suspected by placing one's hand on the abdominal wall. We have had a few interesting cases and are very proud on one particular case which represents the earliest carcinoma of the stomach that I have ever seen. This is one of the non-infiltrative mucosal types, probably multicentric in origin, and was diagnosed on cytologic study with very little clinical or radiological backing. This isolated spectacular example, however, does not furnish a broad

dependable base on which the value of laboratory procedure may be planted. With time and more research into the matter, more simple and dependable techniques may be evolved. Our results range from 21% to 64% in accuracy depending on the technique employed and by whom the specimen is obtained.

SUMMARY

Exfoliative cytology has become established as a worthwhile and dependable diagnostic procedure. It is not a mysterious piece of laboratory mumbo-jumbo, but a respected sub-

division of general pathology, as well founded as hematology or clinical microscopy.

As in all diagnostic procedures, this method must be used sensibly and must be integrated and correlated with other clinical and laboratory findings. Its effectiveness is best exemplified in early carcinoma of the cervix, carcinoma of the lung, and in finding neoplastic cells in pleural and ascitic fluids.

REFERENCES

1. Ackerman, Lauren V.: Surgical Pathology, C. V. Mosby Co., 1953, p. 168.
2. Willis, R. A.: Pathology of Tumours, C. V. Mosby Co. and Butterworth and Co. Ltd., 2nd Edition, 1953, p. 373.
3. Inter-Society Cytology Council: Personal communication.

SUPERB MEDICAL SERVICE

This March, one press release from the American Legion contained all three of the following items:

1. A tribute to the VA and especially Admiral Boone for the VA's "superb medical service" to the sick and disabled veteran.
2. A resolution expressing disapproval of the appointment of the President-Elect of the A.M.A. to the Medical Task Force of the Hoover Commission.
3. A subcommittee's recommendation that a survey be made of the chiefs of professional services and of the veteran patients in VA hospitals to determine "if they desire to have their diseases and disabilities treated by means of chiropractic therapy."

No mention was made of the 4,160 full-time and 936 part-time physicians, the 1,937 residents and interns, and 8,453 consultants and attendants, who had provided 53,407 consulting and 83,724 attending days at an average cost per patient of 46 cents. (Fiscal year 1953 figures).

These, of course, were the men who actually provided the "superb medical service" the Legion praised, and the great majority are A.M.A. members. It is difficult to understand how the VA's medical service can be praised in the same breath that these physicians are ignored, their professional organization insulted, and the admission of chiropractors to the VA considered.

—N. C. PR Bulletin—

... medicine grew up plagued with departmentalization, which has erected barriers to the free flow of knowledge, and, worse, it has developed no organizing principles comparable with those of the organic chemist's with which to find one's way among the clutter of facts. Like a juggler, a physician is forced to

keep as many facts as possible whirling around in his head and not drop too many during his act. Unfortunately, as the reflexes get older, the juggler finds it increasingly difficult to keep the facts he already has, much less add more to the swarm. My professor of organic chemistry at Cornell, Dr. Orndorff, once told me it was not how much organic chemistry I knew that counted but how much I knew about where to find what I wanted to know.

—Irvine H. Page, J.A.M.A., 156, 110-112

We have not been able to change the medical habits of our rural people who have always had plenty of doctors from which to choose. Our efforts to set up clinic hours have meant very little. If the doctor is not at the clinic, they go to his home, church or place of recreation at any hour of the day or night and expect immediate attention.

Rural communities who wish to get and keep a doctor should be more considerate of his time and health. They should curb their impatience over having to wait in turn at the clinic or for house calls and should understand that their doctor often cannot stop whatever he is doing to take care of them immediately. They fail to realize sometimes that it is costly to supply good rural medical care and that a doctor's time and knowledge can only be fully utilized when he has the facilities and trained help and when he wisely uses his time.

Our rural people feel that medical care is a commodity to be purchased by shopping around from doctor to doctor. The old family doctor dependence is rapidly disappearing. This attitude certainly requires that the rural physician be well educated and trained and that he insist upon facilities, trained help and time off for rest and study, if he is to meet the changing pattern of medical care.

J. Paul Jones

A Doctor's Answer To A Community Need

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring -----			82 Rutledge Ave., Charleston, S. C.		
EDITORIAL BOARD					
J. P. Cain -----	Mullins	Vince Moseley -----	Charleston	G. D. Johnson -----	Spartanburg
J. D. Guess -----	Greenville	Ben Miller -----	Columbia	R. M. Pollitzer -----	Greenville
C. J. Milling -----	Columbia	W. H. Prioleau -----	Charleston	Hugh Smith -----	Greenville
H. R. Pratt-Thomas -----	Charleston	J. W. Jervey -----	Greenville	Walter Mead -----	Florence
BUSINESS MANAGER: Mrs. C. G. Watson -----			105 W. Cheves St., Florence, S. C.		
Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½x11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.					
Office of Publication: (In care of the Editor) -----					Charleston, S. C.
Subscription Price -----					\$3.00 a Year

NOVEMBER, 1954

William Lowry Pressly

Since our last issue, we have lost an outstanding figure in South Carolina medicine. Indeed his prestige has not been confined to his native state, and his fame has been recognized widely.

The ideal of the concept of the country practitioner, the family doctor and friend, the alert physician who kept abreast of advances in medicine—these he was notably. With a warm heart and an engaging personality, he made an unusual combination of sound traits and a lovable character.

Elsewhere in this Journal are some tributes selected from among the numerous notices of his passing. Buck Pressly will be long missed by those who knew him.

Latin—Dead and Buried Dog

Latin has been a “dead language” for many a year, yet medical terminology has much to do with it. There are few of us to-day who have more than a sneaking acquaintance with it, barring a few of the declining generation who are inclined to a mild superiority and a tendency to quote unintelligible tags.

A few days ago a professor was expounding the virtues of the antibiotics, and took occasion to remind his students that there was still a vital factor in the *vis medicatrix naturae*, a term which was met with blank faces and a positive denial of all recognition by a collection of some sixteen senior medical students. One thought “nature” was involved somehow, the others thought nothing.

So Latin must be truly dead. O tempora! O vis medicatrix antibioticorum!

Executive Committee State Board of Health

MINUTES

Due to the unexpected death of the State Health Officer, Ben F. Wyman, M. D., a special called meeting of the Executive Committee was held June 23, 1954, in the Office of the State Board of Health

Dr. Wallace welcomed Dr. L. M. Busbee as a new Member of the Executive Committee. He recently was appointed by the Governor, upon the recommendation of the S. C. Dental Association, to replace his brother, C. L. Busbee, D. D. S., who resigned at the last meeting.

It was moved by Mr. Rhodes, seconded by Dr. Barron, that Dr. Guyton be instructed to provide a projectionist for the Pediatric Seminar from the State Board of Health. Passed.

It was moved by Dr. Barron, seconded by Mr. Rhodes, that the Attorney General submit to the Board suitable legislation to remedy the present practice of conducting ex parte proceedings after which by court order the statistics of the Bureau of Vital Statistics are changed without the Bureau ever being party to the proceedings. Passed.

It was moved by Dr. Barron, seconded by Dr. Platt, that the Chairman appoint suitable committee to draft resolutions on the death of Dr. Wyman. Passed.

It was moved by Dr. Platt, seconded by Mr. Rhodes, that Dr. G. S. T. Peebles be elected to the office of State Health Officer. Passed unanimously.

It was moved by Dr. Mead, seconded by Dr. Barron, that Dr. Peebles be authorized to appoint Dr. Guyton as Assistant State Health Officer to act in the absence of the State Health Officer. Passed unanimously.

It was moved by Dr. Mead, seconded by Dr. Platt, that the following resolution be approved: Be It Resolved By The Executive Committee of the State Board of Health; That

Dr. G. S. T. Peeples, State Health Officer, is hereby authorized to approve vouchers of the State Board of Health, and that he is further authorized, together with Mr. W. T. Linton, to approve vouchers issued by the Water Pollution Control Authority, and the Comptroller General is hereby requested to honor same. Be It Further Resolved, that authority heretofore granted Mr. John O. Meetze, Director of Finance of the State Board of Health, to approve vouchers be continued in force. Passed.

It was moved by Dr. Mead, seconded by Dr. Barron, that the recommendation of the Hospital Advisory Council that the State Plan be approved as revised, be approved. Passed.

It was moved by Dr. Barron, seconded by Dr. Smith, that the recommendation of the Hospital Advisory Council Licensing Committee that based on information contained in the questionnaire application completed by Mrs. Mae Holladay that the Oak Haven Rest Home, Sumter, South Carolina, be listed as an institution not requiring a license, be approved. Passed.

It was moved by Dr. Barron, seconded by Dr. Platt, that the recommendation of the Hospital Advisory Council Licensing Committee that the request of the Pine Whispers Rest Home, Myrtle Beach, S. C., for waiver of two exits from the back bedroom (Section 205.1) not be granted, be approved. Passed.

It was moved by Dr. Barron, seconded by Dr. Busbee, that the recommendation of the Hospital Advisory Council Licensing Committee that the request of Mr. C. C. Martin, Owner of Pine Dale Motor Court, Columbia, S. C., for waiver of exit signs (Section 205.10) be granted inasmuch as each room is provided with a door to the outside on grade, be approved. Passed.

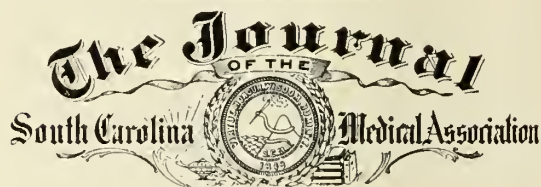
It was moved by Dr. Barron, seconded by Dr. Busbee, that the recommendation of the Hospital Advisory Council Licensing Committee that in lieu of the fire wall with protected openings as required by the action of the Executive Committee on May 10, 1954, Dr. Finger be permitted to install asbestos shingles on the outside face of the exterior wall of the relocated building with metal lath or perforated rock lath and plaster used as interior finish and that insulation of fire-proof material be placed in exterior walls and in ceilings; provided, however, that only ambulatory patients be housed in either the adjacent wing of the existing building or in the relocated building, be approved. Passed.

At the meeting of the Executive Committee, held at Myrtle Beach on May 10, 1954, action on the recommendation of the Hospital Advisory Council Licensing Committee regarding the S. C. Baptist Hospital in Columbia was

deferred. The Committee was informed that the Baptist Hospital has now complied with licensure regulations and has been issued a Class III license for the year ending June 30, 1954. This obviates the necessity of taking action on the recommendations of the Licensing Committee pertaining to this hospital.

It was moved by Dr. Smith, seconded by Dr. Boone, that the Board of Health continue on the present budget with the exception of changes made by recent legislative action. Passed.

It was moved by Dr. Boone, seconded by Dr. Smith, that the staff be instructed to request the Budget & Control Board to change the title of Administrative Assistant to Assistant State Health Officer. Passed.



Forty Years Ago

NOVEMBER 1914

Dr. J. S. Rhame discussed a paper on "Contagion and Disinfection." Dr. Wm. T. Barron presented a paper on "Intraspinal Administration of Salvarsanized Blood Serum." Dr. George Mood read a paper on "Plague" in Charleston.

MINUTES OF COUNCIL MEETING COLUMBIA, S. C., SEPT. 29, 1954

A special meeting of Council was held in the Columbia Hotel, Columbia, S. C. at 3:30 p. m. September 29, 1954. Members present were Dr. Cain, Chairman, Drs. Waring, Baker, Mayer, Guess, Gaines, B. Smith, Weston, Bozard, Wyatt, Gressette, Morgan, Crawford, Stokes, Sease, Burnside, Wilson and Mr. M. L. Meadors. Also present during the first part of the meeting were several members of the State Board of Medical Examiners.

The minutes of the meetings of May 10, 11, 12 and 13, 1954 were approved as published in the Journal.

As the first order of business the Chairman asked the members to report on the present status of the legal aspects of the Naturopathic situation in the state and this was done. Dr. Cain asked each Councilor to report on the questions asked before the primary election of legislators in June 1954, and a report from each member of Council was given. Dr. Adcock spoke in regard to the attitude of the State Board of Medical Examiners

in this matter and considerable general discussion followed.

The Secretary then moved that Council advocate the repeal of all enabling acts relative to the practice of Naturopathy in the State. This motion was passed by a vote of seven to four. Dr. Gressette then moved that before Council takes further action each Councilor be asked to appraise the temper and feeling of all Legislators in his district and be prepared to report back to Council at another called meeting in approximately two months time. It was further moved to invite all members of the Committee on Legislation to meet with Council at this next meeting, and these motions were passed.

The Chairman then presented matters relative to the budget and the following items were approved for the current year:

Historical Commission	\$ 500.00
Infant Mortality Committee	200.00
Expense of President (\$50 per month)	600.00
President's gift up to	200.00
Essay Contest	175.00
Treasurer's Office	100.00
Travel for Delegates	1000.00

The President pointed out that the cost of printing of the Journal would probably exceed the expenditure for this item during the past year and invited discussion in this regard. As no definite figures could be proposed the actual figure to be put in the budget for this purpose was deferred.

Dr. J. I. Waring reported on progress in the securing of a publicity agent for the Association but stated that no final action had been carried out. Dr. Gressette suggested that the best way to find out what would be best in this regard would be to invite various newspaper editors to a dinner to discuss this matter and advise the Association, and Dr. Mayer moved that Dr. Gressette be asked to consult with the publicity committee to see if such a meeting could be arranged. This motion was passed.

The finances and expenditures of the Annual Meeting of the Association were discussed at some length, including the cost of speakers, traveling expenses and other items of expense and the surplus of rentals from commercial exhibitors. Council directed that the program committee of the Association should meet with the Finance Committee of Council to try and determine just what expenditures could be allowed for purposes at the Annual Meeting.

Dr. Charles Wyatt took the chair and Dr. J. P. Cain reported for the Insurance Committee at some length. The Committee presented for approval the following recommendations:

1. That the Association employ a professional insurance man to take over the problems confronted in this program, namely:

A. To act as a consultant with the Committee in order to determine the most suitable form of insurance to answer the needs of the individual members of the Association, both as to life insurance coverage and to retirement income coverage.

B. To submit this plan as finally agreed upon with the Insurance Committee to numerous old line life insurance companies with national reputations whose financial responsibility is unquestioned, and to receive from them competitive rates.

C. To analyze these replies and submit the best four or five proposals to the Committee and to Council for adoption by the Association.

D. After a company has been selected, this person is to sell the insurance to the doctors for the Association.

E. This person is to be the agent who shall be responsible for the collection of premiums for the Association.

F. The expense of employing such a person shall not be borne by the Association, but shall be the commissions which he shall collect from the company which issues the insurance.

This motion was passed unanimously and the recommendation of the Committee to employ Mr. Ransome Williams to represent the Association in this capacity was likewise approved. Council expressed their thanks to the Insurance Committee for their work on its behalf.

Dr. Bozard asked if anything could be done to help the public differentiate between Blue Seal and Blue Shield Insurance and Dr. Guess reported that a law suit in Texas was now underway but was doubtful if anything could be done in regard to this situation. Dr. Bachman Smith asked if members of the Association could be reprimanded in any way for misuse of Blue Cross and Blue Shield Insurance but no action was taken.

Dr. Stokes reported on the influx of new doctors in the coastal area of the state during the summer months and it was pointed out that these physicians would need a license to practice medicine in the state in order to do so and that hospital privileges would depend on the local county medical societies. Questions were also asked regarding naturopathic physicians in hospitals and their eligibility for Blue Shield Benefit and Dr. Guess stated that these were not eligible for remuneration from the Blue Shield Plan.

Dr. J. P. Cain reported on a graduate of a foreign medical school practicing medicine in a hospital at Mullins and asked Council what should be done. Dr. Burnside moved that this matter be referred to the Legislative Committee for suggestions and for proposed action and a motion to this effect was passed.

Dr. Guess suggested that Council revert to a discussion of the budget and that the salary of the Executive Secretary be reconsidered. It was

moved that the salary be raised \$1000 a year retroactive to June 1, 1954 and a motion to this effect was passed.

Dr. O. B. Mayer asked if the Woman's Auxiliary of the Association could undertake anything in regard to Naturopathic practice in the state and action on this was deferred until after the next meeting of Council.

The Chairman was then authorized to appoint a committee to consider a suitable memorial to the late Dr. W. L. Pressly and that the Chairman inform Dr. Pressly's family of any undertaking of the Association.

The Secretary reported the receipt of an inquiry from Dr. W. H. Powe, Jr., Secretary of the Greenville County Medical Society in regard to Honorary Membership in the State Association, and his reply that such membership depended altogether on active dues paying membership in the Association for 40 years. This was confirmed by Council.

The Secretary further reported: a. Receipt of letters from Dr. W. S. Hall and Dr. B. O. Whitten, which were received as information. b. An inquiry from the AMA in regard to ethical problems in the state, the reply to which was confirmed by Council. c. Some plans for the coming meeting in Charleston in 1955, received as information. d. Quotations of Mr. M. L. Meadors and Dr. George D. Johnson in the Secretary's Letter from the AMA. e. A suggestion that the Committee on Legislation and the Counsel of the Association be requested to make an effort to have the state law to conform with the more liberal new federal law in regard to the oral prescription of narcotics, and the Treasury Department's ruling in this regard. A motion adopting the latter was passed.

There was no further business to come before Council and adjournment took place at 7 p. m.

Respectfully submitted,

Robert Wilson, M. D., Secretary

ANNOUNCEMENTS

The Journal is very glad to have announcements and news of meetings and other events of medical interest. The Journal is mailed about the 15th day of each month. In order to have items appear in any given issue, they should be in the hands of the editor by the 20th day of the preceding month.

AMA MIAMI MEETING!

Sunny skies, swaying palms and broad sandy beaches are but a few of the attractions Miami offers physicians and their wives planning to attend AMA's eighth annual Clinical Meeting Nov. 29 - Dec. 2. An excellent scientific program—including lectures, exhibits, motion pictures and color television—plus a large array of technical exhibits have been lined up for AMA visitors.

ONE DAY POSTGRADUATE COURSES IN SPECIAL SUBJECTS

These were established at the suggestion of the Georgia Academy of General Practice and were offered the first time during the school year 1953-1954. They are scheduled for the first Thursday of each month beginning in October and extending through May with the exception of December as the three day postgraduate course will be offered that month.

Thursday, November 4—Cardiovascular Disease

Thursday, January 6—Orthopedic Surgery

Thursday, February 3—Arthritis

Thursday, March 3—Diabetes

Thursday, April 7—Surgery

Thursday, May 5—Psychosomatic Medicine

Minimum registration for each course 15.

Registration fee \$5.00.

Address all Communications to the
DIRECTOR OF POSTGRADUATE EDUCATION
Emory University School of Medicine
69 Butler St., S. E., Atlanta 3, Ga.

DOCTORS INVITED TO JAMAICA MEDICAL MEETING

Members attending the AMA Interim meeting in Miami are invited to a post-convention meeting of the British Medical Association, Jamaica Branch, at Kingston, capital city of the Island, on Saturday, December 4, at 10:00 A. M.

The invitation comes direct from the president and officers of the Jamaica Association, which was founded in 1877.

Jamaica is reached from Miami by airliner in a pleasant 2-1/2 hour trip over the Gulf Stream, across Cuba and a corner of the Caribbean Sea. Following the close of the AMA meeting on Thursday, December 2, doctors and their wives could fly to Jamaica on Friday, attend the British Medical meeting Saturday forenoon, December 4, then enjoy the attractions of the popular tourist island as long as desired, returning to Miami by several daily air schedules in about three hours.

Further details will be available at Information Desks at the Miami meeting, from American Express Company and local travel agents, or from the Miami office of the Jamaica Tourist Board, 1631 duPont Building.

The ninth annual UNIVERSITY OF FLORIDA MIDWINTER SEMINAR IN OPHTHALMOLOGY AND OTOLARYNGOLOGY will be held at the Sans Souci Hotel in Miami Beach the week of January 17th., 1954. The lectures on Ophthalmology will be presented on January 17th., 18th., and 19th. and those on Otolaryngology on January 20th., 21st., and 22nd. A midweek feature will be the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology on Wednesday afternoon, January 19th., to which all registrants are invited. The registrants and their wives may also attend the informal banquet at 8 p. m. on Wednesday. The Seminar schedule permits ample time for recreation.

The Seminar lecturers on Ophthalmology this year are: Dr. William F. Hughes, Jr., Chicago; Dr. Phillips Thygeson, San Jose; Dr. James Allen, New Orleans; Dr. Walter H. Fink, Minneapolis; and Dr. Milton L. Berliner, New York. Those lecturing on Otolaryngology are: Dr. Paul Hollinger, Chicago; Dr. Lawrence R. Boies, Minneapolis; Dr. Edmund P. Fowler, Jr., New York; Dr. Arthur W. Proetz, St. Louis and Dr. David D. DeWeese, Portland, Oregon.

THE ATLANTA SOCIETY OF NEUROLOGY AND PSYCHIATRY Meeting to be held in Atlanta on November 17th. The guest speaker will be Dr. Joseph C. Yaskin, who is Professor of Neurology at the University of Pennsylvania Graduate School. The subject of his talk will be "Recent Advances in Neurology." The meeting will be held at 7 o'clock at the Academy of Medicine in Atlanta.

BOOK REVIEWS

TEXTBOOK OF PEDIATRICS—Edited by Waldo E. Nelson with the Collaboration of Seventy Contributors. Sixth Edition. W. B. Saunders Co., Philadelphia and London. 1954. Price \$15.00.

This book comes of a noble lineage, being the great grandchild of the older textbook of Griffith, which was followed by Griffith and Mitchell, then by Mitchell and Nelson, and now appears in its Sixth edition in the name of Waldo E. Nelson. It includes a fine array of contributors and covers in its 1500 pages an admirably wide field of pediatric matters.

Like its predecessors, this textbook is well suited to the uses of student and general practitioner, and offers to the pediatrician an excellent source of reference. It is probably the best single volume work in its field, and its popularity in the past will no doubt be duplicated in the future. It can be recommended wholeheartedly.

J. I. W.

THE PHYSICIAN AND HIS PRACTICE—Edited by Joseph Garland—Little, Brown and Co., Boston—Price \$5.00.

Nineteen contributors are here marshalled under Dr. Garland's editorship to provide primarily for the young doctor a fund of information which should cover the problems of the decisions which must be made in mapping a medical career. The subjects include practically all phases of medical practice and social relations. Some subjects are treated in generalities, others in more specific fashion and all of them are sufficiently interesting to warrant a close consideration.

There are probably not many books of this nature as inclusive as this one is, and the matters considered are of quite current interest. Not only the budding physician but also the confrere who is beginning to wither on the vine might read this to advantage. The volume reminds us of an earlier, somewhat less elaborate, but still worthy companion, Wingate Johnson's *The True Physician*, which said almost as much in less space and withal in a very pleasing way.

The multiplicity of authors naturally makes the style rather uneven, but there is much good material here, and the whole book is readable.

Several things seemed to warrant some mention, among them the dull picture painted of the general practitioner (generalist, if you would follow Dr. Means) in the city. If it is true, it is discouraging. Good advice on the proper kind of medical library, and the matter of medical writing is to be found. There is some detail in the matter of laboratory and office equipment; in the latter one might quibble over the use of trade names, and might suspect that the "internal timer" is the result of a printers' nod. It seems that the subject of charging for telephone calls might not be dismissed so finally. In the matter of office accounts, no mention is found of the simple and ready made "logs" or financial record systems which many physicians find handy and inexpensive. But these things are not vital, but rather *de gustibus*.

J. I. W.

FUNDAMENTALS OF ANESTHESIA. Prepared under the editorial direction of the Consultant Committee for Revision of Fundamentals of Anesthesia, a publication of the Council on Pharmacy and Chemistry of the American Medical Association. Third Edition. W. B. Saunders Company, Philadelphia and London 1954.

Contributions to the formation of this volume were made by sixteen authors, all outstanding in their field of endeavor. This edition has been rearranged and rewritten and is a definite advance over previous editions.

The first two chapters present a brief but adequate review of the basic principles of physiology, chemistry and physics applicable to anesthesia. This is followed by a general consideration of anesthesia and includes preanesthetic care, general and regional anesthesia, special applications, post-anesthetic care, complications, inhalation therapy, hazards, and anesthetic records. The book contains 89 illustrations and 19 tables. The appendix contains tables of equivalents and standard values and agents used in regional block anesthesia which can or can not be reesterilized by autoclaving.

There are a few assertions made that might be open to criticism. However, as is indicated in the preface by Dr. Stormont, the necessity for brevity of the text may make some statements appear dogmatic.

The book is recommended both for reference and leisure reading for all interested directly or indirectly in anesthesia. The volume is so constituted as to be valuable for use as a textbook for students of anesthesia.

John C. Doerr, M.D.

PERIPHERAL CIRCULATION IN MAN. A Ciba Foundation Symposium. Little Brown and Company, Boston, 1954. 219 pp. \$6.00.

This volume contains about 18 topics each presented by an active investigator in that particular field. The presentation is usually followed by critical comments and questions. Although the majority of the participants are from England, the distribution is broad and there are representatives from other countries, four being from the United States. The emphasis throughout is meant to be provocative in areas of advanced experimentation and there is difficulty in extracting very much in the way of established facts and principles which are immediately useful in a practical way. It is highly informative however to recognize the variety and scope of new concepts which are in the making. The versatility of new techniques is also impressive. Electronic timing circuits have been used to improve the accuracy of the conventional plethysmographic principle; strain gauges have been used from recording changes in limb girth; radio-isotopes have to some extent superseded dyes for measuring changes in blood flow; transparent chamber techniques for direct microscopic observations of vessels have been further modified. Perusal of this volume will be profitable to anyone seeking new ideas in this specialized field.

R. P. Walton

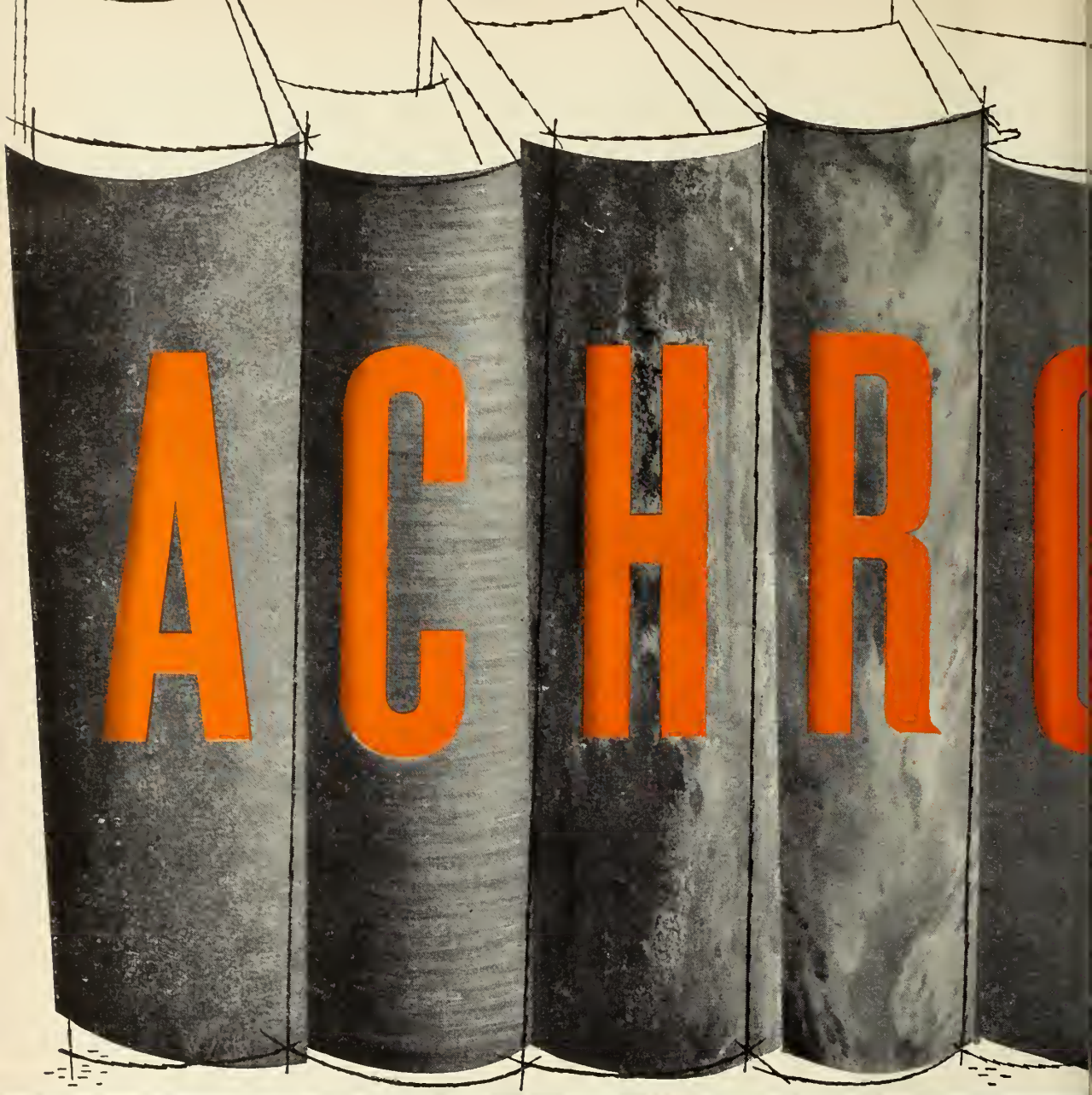
SURGICAL FORUM: CLINICAL CONGRESS OF THE AMERICAN COLLEGE OF SURGEONS. W. B. Saunders Co., Philadelphia. 1954. Price \$10.00.

This volume of 752 pages contains papers delivered at the Forum Sessions of the Clinical Congress in October, 1953. It is devoted largely to laboratory and clinical research into fundamental surgical problems.

Of interest is the fact that almost one-third of the book is concerned with papers on the heart and blood vessels. This indicates the tremendous strides that are being made in the surgery of the cardiovascular system. Each group of papers is introduced by a summary of the current problems in the particular field by a well recognized authority.

This is a reference volume which should be in the hands of every doctor interested in current basic clinical research.

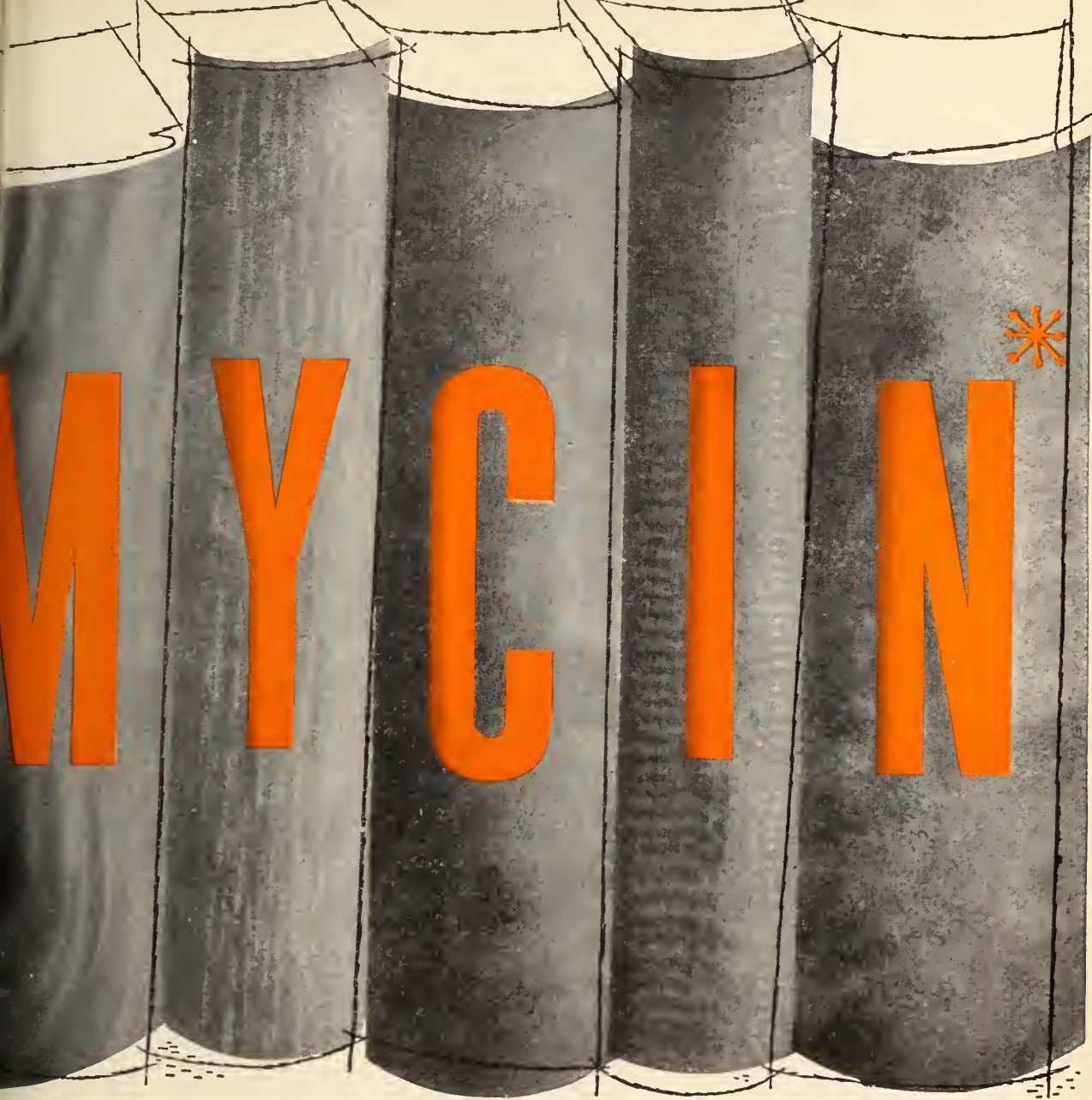
Fred Kredel, M.D.



Medical history is being written today



• REG. U.S. PAT. OFF.



Hydrochloride
Tetracycline HCl Lederle

The introduction and rapid widespread adoption of ACHROMYCIN has opened a new chapter in the history of broad-spectrum antibiotics.

ACHROMYCIN fulfills the requirements of the ideal antibiotic in virtually every respect . . . wide-range antimicrobial activity, *in vivo* stability, tissue penetration, minimal toxicity.

ACHROMYCIN is truly a broad-spectrum weapon, effective against Gram-positive and Gram-negative

bacteria, as well as certain mixed infections.

ACHROMYCIN is more stable and produces fewer side effects than certain other broad-spectrum antibiotics.

ACHROMYCIN provides prompt diffusion in body tissues and fluids.

ACHROMYCIN is destined to play a major role among the great therapeutic agents.



WILLIAM LOWRY PRESSLY

**DR. BUCK PRESSLY: A MAN DEVOTED
TO HIS PEOPLE**

He was of that beloved yet rapidly vanishing tribe—the “family doctor” or general practitioner—and Dr. W. L. (Buck) Pressly of Duc West could tell you how it felt to be something of an anachronism in an Age of Specialists. It felt wonderful because that is what he chose to be.

The measure of this great and good man is found both in the national recognition and acclaim that came with his nomination as “Doctor of the Year” in the United States in 1948 and in the quiet love and devotion accorded him by the thousands of persons to whom he had ministered.

His record of unselfish service to his fellow man

stands as a monument to his belief that a doctor, having taken the Oath of Hippocrates, should strive at all times to fulfill the exacting precepts of that pledge.

Soon or late, flesh not being immortal, the ravages of years, of unselfish toil, entailing long and irregular hours, and the inevitable erosion of time must claim their toll. So it was with the passing yesterday of Dr. Pressly.

He was a believer in the healing power of kindness and encouragement, knowing full well that pills and drugs and the remarkable achievements of modern science often are not quite enough. He felt that despair, like disease, must be conquered.

A brave and tender man, a devoted Christian, and

a consecrated physician, he labored for the health and happiness of the people in the little corner of the world in which he chose to live, shunning the fame and richer material rewards that a man of his ability could have had for the asking in vast cities and great hospitals anywhere in this land.

We will not see his like again.

—Anderson (S. C.) *Independent*

1949 GENERAL PRACTITIONER DIES. Dr. W. L. "Buck" Pressly, Due West, S. C., recipient of the A.M.A. General Practitioner Award in November, 1948, and one of the most genial and best-liked doctors of "the old school," passed away on September 27 at the age of 67.

Dr. Pressly, who served as a member of the A.M.A. Council on Medical Education and Hospitals from June, 1948, through June, 1954, practiced medicine in his home town for more than 35 years and was considered an authority in his state on rural health and sanitation.

He had a colorful story to tell when he received the family doctor of the year award. Dr. Pressly played baseball before entering medical school. He played professional ball from 1908 through 1914 with the Roanoke and Norfolk, Virginia, teams, and managed pennant-winning teams in both cities. He turned down an offer from the Pittsburgh Pirates to enter medical school.

When he received the A.M.A. award, he provided newsmen with some fine feature copy. With a chuckle, he often recalled his early days of practice when he was gone so long on a horse and buggy tour of his area that his dogs barked at him when he returned home.

—Secretary's Letter—*American Medical Association*

DUE WEST, S. C., Sept. 27—Dr. William L. (Buck) Pressly, the nation's Family Doctor of the Year in 1948, died at his home here today at the age of 66 after several months ill health.

The kindly 6 foot 1 man who forsook a professional baseball career to minister for almost 40 years to the folk in and around his native Due West was first stricken at the bedside of a patient last May.

He wore out 22 model T Fords on rough roads hereabouts. When he was honored in 1948 by the American Medical Assn. he estimated that he had delivered 4,200 babies including 16 sets of twins, in Due West, population about 2,500, and vicinity.

Dr. Pressly played baseball summers to get money for his medical education at Emory University, Atlanta, Ga.

As first baseman-manager he won Virginia League pennants at Roanoke in 1912 and Norfolk in 1914.

He turned down an offer from the Pittsburgh Pirates to come back as a horse and buggy family doctor to the people in Due West, where his father was professor of Greek and Latin at Erskine College.

The first three years he used a horse and buggy in winter before switching to the model T.

Due West in the South Carolina Piedmont was established more than a century ago as Dewitt's Corner, an Indian trading post. It was moved two miles due west to get near the Indian trail, and has been known as Due West since.

In speeches after he won the General Practitioner Award gold medal, Dr. Pressly said medical service to rural communities was the American Medical Assn.'s No. 1 problem. He also deplored the tendency to what he described as socialized medicine.

—*Charleston News and Courier*

In the soft darkness of an autumn day he left us on his last journey. There was no mistaking the knock at the door and the gentle rustle of the angel's wings that

filled the room. The strong hands that had helped so many babies into the world and held with a steady grip the frail thread of life, now lay still on the white counterpane. The tired eyes, weary with endless watching a tortuous country road, were closed. The kindly heart had ceased to beat, and the peace of God ineffable, was upon his face.

There is but one heart today in this little town, and it is sore.

How shall we pay him tribute? How estimate the healing medicine of his vibrant jolly presence? Oft have we sat beside a sick child, anxious and weary, and felt our hearts lift at the sound of his footsteps upon the porch. Better than all the elixirs of science was the tonic of his presence. On his strong shoulders we placed the burden that was beyond our bearing. It was but added to the many others that he bore.

For several months we had noted the weariness in his face and the effort he made to walk with his usual vigor. But no word of complaint passed his lips, no indication was given of the pain he must have suffered, physically and vicariously. He carried his patients on his heart, day and night. It was not only his fine knowledge of human anatomy and medicine that made him such a wonderful diagnostician. It was the deep love of humanity and the marvelous power of healing. He studied every case and was as glad as the patient, when he could heal. He had a wonderful constitution, but even steel will break. The loss of many hours of sleep, the irregular and sketchy meals, the constant grueling pace, the endless errands of mercy through summer heat, and rain, and bitter cold; the heartbreak at the going away of his bonny boy and the death of his wife; all these he bore with a courage, indefinable. For over forty years he fought death for rich and poor, for young and old, for black and white; but his time came at last.

We shall miss the joy of his presence. We shall long to hear his booming laugh and feel the strength which flowed from his handshake.

He loved life and he loved living. Blessed is he who has found his work; let him ask no other blessedness. All who have meant good work with their whole hearts have done good work, although they may die before they sign it. Every heart that has beat strong and cheerfully has left a hopeful impulse behind it in the world, and bettered the tradition of mankind.

We can not yet believe that he is gone. In the full tide of his usefulness, ripe with the study and experience of many years, sorely needed by many who were helped by his skill and cheered by his courage, it will come to us gradually that he has passed beyond this bourne of time and place.

Death has not been suffered to take so much as an illusion from his heart. In the hot-fit of life, atiptoe on the highest point of being, he passes at a bound on the other side.

"Almighty God, dinna be hard on William Lowry Pressly, for he's no been hard on anybody in Due West. Be kind to him as he's been kind to us for many a year. Forgive him for what's he done wrong and dinna cast it up to him. Mind the fouk he helpit—the weemen and the bairnies and gie him a welcome home, for he sair needin' it after all his work. Amen.

—Mrs. Agnes C. Long in *The Due West Weekly*

NEWS

Dr. C. H. Young of Anderson was elected president of the Piedmont Post-Graduate Clinical Assembly in the second and final day's session of the annual meeting, held at the Clemson House. Dr. Young succeeds Dr. Hugh Smith of Greenville as leader of the group.

Other officers are Dr. William Klamber, Greenwood, executive vice president; Dr. Thomas Goldsmith,

Greenville, vice president; Dr. Hubert Milford, Hartwell, Ga., vice president; Dr. Ned Camp Anderson, secretary-treasurer; and Dr. Frank Warder, Anderson, registrar.

The group voted to meet again next year at the Clemson House. Dr. William Hendricks of Spartanburg presided over the sessions this year.

The two-day meeting included lectures and discussions by a number of distinguished leaders in the field of medicine, and was attended by a large group of physicians from South Carolina and Georgia.

The meeting was concluded last night by a dinner and a lecture by Dr. Robert L. Brown of Emory University School of Medicine.

A luncheon talk and election of a new president closed the sixth annual meeting of the South Carolina Academy of General Practice in Columbia, September 29th.

Dr. Thomas R. Gaines of Anderson was the principal speaker on the day's program, at a luncheon.

Dr. Kirby D. Shealy of Columbia was elected president, succeeding Dr. W. Wyman King of Batesburg.

Named pre-president-elect was Dr. Hervey W. Mead of Pendleton.

Dr. Homer Eargle of Orangeburg was chosen vice president and Dr. Horace M. Whitworth of Greenville was re-elected secretary-treasurer.

Dr. M. W. Hook and Dr. J. C. Thraillkill announced this week plans to practice medicine in partnership upon completion of the clinic now being erected on Third Street, Cheraw.

As of September 1, Veterans Administration had only two service-connected cases awaiting hospitalization. At the same time 19,878 non-service cases had qualified for treatment and were awaiting hospitalization. For August, the average VA daily patient load was 109,450, compared with 105,486 in August 1953.

According to Marion B. Folsom, Undersecretary of the Treasury, the administration still is interested in the problem of the "retirement income of people not covered by pension plans." Mr. Folsom made his remarks in a review of the administration's legislative progress during the last year. He noted that the President has reserved this problem "for further study." This idea, basis of the Jenkins-Keogh plan, for years has had the support of the American Medical Association. The objective is to allow self-employed persons to defer income tax on a part of their income, providing it is put into restricted annuity plans.

ATTORNEY GENERAL'S NATUROPATH RULING BACKED BY JUDGE

SPARTANBURG, Oct. 12—Circuit Judge E. H. Henderson has backed State Attorney General T. C. Callison in one phase of a legal fight being waged against him by the S. C. Naturopathic Assn.

The attorney general had ruled that naturopaths do not have the right to administer drugs. Callison filed a demurrer (legal objection) to the suit and judge Henderson sustained him in it.

The naturopaths sought an order from the court that they have the right to administer narcotics under the laws of South Carolina. Attorneys for the naturopaths said they will appeal to the Supreme Court.

The action was initiated by two officers of the association, Dr. J. B. Branyon of Spartanburg and Dr. M. S. Dantzler of Orangeburg County. Under state law such practitioners are allowed to do minor surgery and obstetrics. They contended it is unreasonable to perform minor surgery or obstetrics without the use of modern drugs.

(*Charleston News and Courier*)

Dr. Robert C. Grier, Jr., a graduate of Vanderbilt School of Medicine, has opened an office at 123 Mallard St., Greenville for the practice of orthopedic surgery.

STATE HOSPITAL ADDS TO STAFF

Dr. Helen M. Williams (Mrs. James H. Williams) is assigned to the State Park Division as an assistant physician. A graduate of the University of Texas, Medical Branch, Galveston, Tex., Dr. Williams has been in private practice and has had special training in special and general hospitals.

Dr. Jane N. Higbee (Mrs. Dale S. Higbee) has assumed her duties as an assistant physician at the Columbia Division of the hospital. A graduate of the University of Texas, Medical Branch, Galveston, Tex., Dr. Higbee has had wide experience in the VA Hospital, Waco, Tex., and in the Austin State Hospital, Austin, Tex.

Dr. George R. Laub of Columbia has been made a diplomate fellow of the International College of Surgeons.

Dr. John A. Workman, well known Woodruff physician, who has been serving with the U. S. Naval Medical Corps for the past several months, has returned home and is now associated with Dr. B. J. Workman, Sr., in the practice of medicine and surgery at the Workman Memorial Hospital.

Dr. W. P. Beckman has been chosen Presbyterian College Alumnus of the Year, and was presented the Alumni Gold "P".

Dr. William S. Hall, superintendent of the South Carolina State Hospital, was elected president of the Southeastern Society of Neurology and Psychiatry, September 28th.

Other officers: Dr. C. E. Jump, Augusta, Ga., first vice president; Dr. Joe E. Freed, Columbia, second vice president; Dr. James B. Galloway, Columbia, secretary-treasurer.

Dr. Julius Earle has opened offices in Walhalla for the practice of medicine on South Catherine Street. Dr. Earle is a native of Walhalla.

Dr. James Dixon, well known Anderson physician, has closed his office. He will leave for San Antonio, Texas, where he will enter the Army for a two-year tour of duty.

Dr. Basel Mixon of Orangeburg is now resident in anesthesiology at Walter Reed Hospital, Washington. His address is 10406 Muir Place, Kensington, Maryland.

Dr. Ed. Proctor of Conway has passed the examination of the American Board of Surgery.

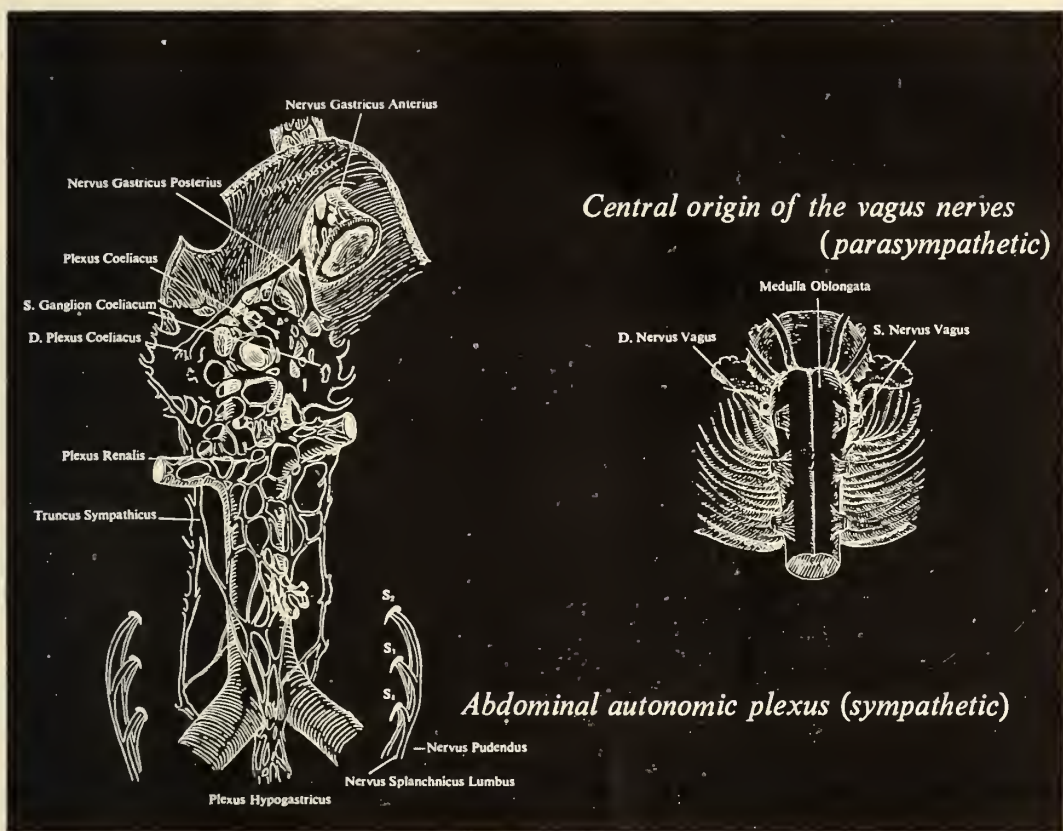
The Coastal Medical Society held its first meeting of the 1954-55 season at the Southland Diner, Walterboro, on Sept. 16th. A talk on "Certain Aspects of Liver Disease" was given by Dr. Robert Wilson, Charleston.

DEATHS

DR. JOHN NEWTON GASTON

Dr. John Newton Gaston, 82, of Edgemoor died September 21, 1954.

Dr. Gaston attended the Banks Military Academy, Erskine College and was graduated from the Medical



Control of Gastric Motility and Spasticity in Peptic Ulcer with Banthine®

"The need¹ for suppressing gastric motility and spastic states is . . . fundamental in peptic ulcer therapy. Since the cholinergic nerves are motor and secretory to the stomach and motor to the intestines, agents capable of blocking cholinergic nerve stimulation are frequently used to lessen motor activity and hypermotility."

Banthine² "has dual effectiveness; it inhibits acetylcholine liberated at the post-ganglionic parasympathetic nerve endings and it blocks acetylcholine transmission through autonomic ganglia."

It has been shown¹ to diminish gastric motility and secretion significantly as well as intestinal and colonic motility.

The usual schedule of administration in peptic ulcer is 50 to 100 mg. every six

hours, day and night, with subsequent adjustment to the patient's needs and tolerance. After the ulcer is healed, maintenance therapy, approximately half of the therapeutic dosage, should be continued for reasonable assurance of nonrecurrence.

Banthine® (brand of methantheline bromide) is supplied in: Banthine ampuls, 50 mg.—Banthine tablets, 50 mg.

It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. Searle Research in the Service of Medicine.

1. Zupko, A. G.: Pharmacology and the General Practitioner, GP 7:55 (March) 1953.

2. McHardy, G. G., and Others: Clinical Evaluation of Methantheline (Banthine) Bromide in Gastroenterology, J.A.M.A. 147:1620 (Dec. 22) 1951.

College of South Carolina in 1899, at which time he went to Edgemoor, and had practiced in the same community for the past 55 years.

Survivors include two sons, Dr. Frank P. Gaston of Rock Hill and Dr. John Newton Gaston, Jr.

DR. JOHN KING GARNETT TUTEN

Dr. John King Garnett Tuten, 65, prominent McCornick physician, drowned September 23 in the Little River.

Doctor Tuten, a graduate of the University of Georgia, was a practicing physician the past 42 years. He was a veteran of World War One and a Mason.

CORRESPONDENCE

Thomas Gaines, M. D.
President, State Medical Society
126 E. Earle St.
Anderson, S. C.
My dear Doctor:

Due to the shortage of naval medical officers on active duty, resulting from the reduction in the allowed ratio of doctors per thousand of other personnel on active duty, it is the desire of the Surgeon General of the Navy to ascertain the availability of civilian physicians to conduct medical work in certain Navy shore establishments. These establishments are comprised of Naval shipyards, ammunition depots, supply centers, air stations and other naval industrial installations.

Appointments or contracts, on a whole or part time basis, would be feasible under conditions proposed by the Surgeon General as follows:

a. Regular Civil Service appointments to classified positions ranging from a minimum grade of GS-11 to a maximum grade of GS-13, dependent upon the size of the establishment and the number of persons employed.

b. Employment of experts or consultants under personal service contracts.

c. Services procured on call.

Services procured under a Civil Service appointment, a. above, are of the type which are termed "whole time". Under the laws and regulations pertaining to Civil Service appointees, this employment would be for eight hours a day five days a week, i. e., forty hours a week, with annual and sick leave rights. The minimum annual salary under the GS-11 appoint-

ment is \$5940. Under the GS-12 and GS-13 appointments, the minimum salaries are \$7040 and \$8360, respectively.

Services procured under the provisions of the personal service contract, referred to under b. above, will be in accordance with the terms of a contract as mutually entered into by the physician and the Navy. This type of contract will neither be adaptable to nor required by all establishments. Compensation under these contracts will be fixed by the contract.

Services procured, or rendered, "on call" will be either by contract mutually entered into between the physician and the Navy, the terms of which will specify the conditions and fees, or by informal agreement to render services as required and when called.

Under the reduced ratio of naval medical officers allowed on active duty the Navy is, and will continue to be for an indefinite time, operating under a difficult handicap in furnishing adequate medical care to naval and civilian personnel at its continental shore establishments. In view of the existing conditions I will appreciate any information you might have or be able to acquire and furnish me, including a listing of interested physicians in your state who might be interested in the proposed program which is outlined above.

Sincerely yours,
R. A. WALLACE
Commander, MC, USNR
Asst. to District Medical Officer
U. S. Naval Base, Charleston, S. C.

ESTES SURGICAL SUPPLY COMPANY

Phone WALnut 1700-1701

56 Auburn Avenue

ATLANTA, GA.

SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE

TO ALL MEMBERS OF THE SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE AND ALL GENERAL PRACTITIONERS IN SOUTH CAROLINA

Our Academy has just had one of its best annual meetings. The program was of the highest type and every lecture was well attended. We had the best attendance we have ever had (224 doctors registered). Dr. Russell Cecil, author of our text book of medicine, now age 75, still keen and alert and well preserved physically, was an inspiration to us all. To those of you who missed this meeting let me urge you now to resolve to make every effort to attend our next meeting, for we plan to keep our meetings of the highest order and of interest to all general practitioners.

Our academy is growing steadily both nationally (20,000 members) and locally in our South Carolina Chapter. To those of you who are not yet members let me urge you to seriously consider joining this year. We hope that every general practitioner in South Carolina who is not a member can be contacted during the year and his membership enrolled.

One of our projects in South Carolina is to support and attend the Post Graduate Seminar and Founders' Day program put on once a year by our Medical College under the direction of Dr. John T. Cuttino, Dean. Again this year he has arranged an excellent program for November 2, 3, and 4th. These programs are arranged largely for our benefit and deserve our support. Members of our Academy get 25 formal credits for attendance so let me urge you again to be in Charleston, November 2nd, 3rd, and 4th to attend this meeting.

To our members, I want to express my sincere appreciation for your confidence in electing me as your president for 1954-55. Our Academy has done well since its organization six years ago and my hope is that we can keep it growing and progressing in South Carolina. I pledge you my best efforts during the coming year.

Yours sincerely,
Kirby D. Shealy, M. D., President

HIGHLAND HOSPITAL, INC.

FOUNDED IN 1904
ASHEVILLE, NORTH CAROLINA



Affiliated with Duke University.

A non-profit psychiatric institution, offering modern diagnostic and treatment procedures — insulin, electroshock, psychotherapy, occupational and recreational therapy — for nervous and mental disorders.

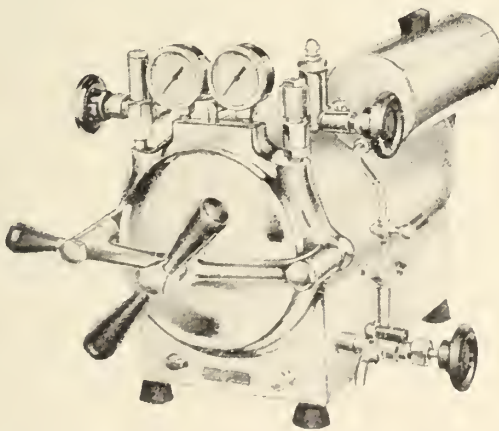
The Hospital is located in a 75 acre park, amid the scenic beauties of the Smoky Mountain Range of Western North Carolina, affording exceptional opportunity for physical and nervous rehabilitation.

The OUT-PATIENT CLINIC offers diagnostic services and therapeutic treatment for selected cases desiring non-resident care.

R. Charman Carroll, M.D., Diplomate in Psychiatry. — Medical Director.

Robt. L. Craig, M. D., Diplomate in Neurology & Psychiatry, Associate Medical Director.

Do you protect your patients with antitoxins and antibiotics
and then expose them to the danger of virus infection?



FL-2 Autoclave chamber is 6" x 12"; HP-2, 8" x 16". Both are self-contained, efficient and easy to operate.

**PROTECT YOURSELF,
YOUR PATIENTS, WITH
A PELTON AUTOCLAVE**

To the private office, a Pelton FL-2 or HP-2 Autoclave brings the *safety* plus the *speed* of hospital sterilization. It provides certain destruction of bacteria and safely handles fabrics, gloves, and solutions, as well as instruments. Call or write today for literature on Pelton Autoclaves.



W i n c h e s t e r

CAROLINAS HOUSE OF SERVICE



Winchester Surgical Supply Co.
119 East 7th St. Tel. 2-4109 Charlotte, N.C.

Winchester-Ritch Surgical Co.
421 W. Smith St. Tel. 5656 Greensboro, N.C.

PRESIDENT'S PAGE

It was a disappointment that we could not accept the invitation to be with the Seventh District at its meeting in Bishopville due to the fact that we were in attendance at the International Congress of Ophthalmology in New York at the time. We especially wanted to attend this meeting since we had not had the opportunity of being in that vicinity before.

The South Carolina Chapter of the American Academy of General Practice had a very interesting and informative meeting in Columbia. It was a pleasure to have the opportunity of greeting so many of our members and to take part in the program. The address by the national President was the highlight of this meeting. Then there were many able men on the scientific program.

The South Carolina Chapter of the American College of Surgeons will hold its fourth annual meeting at the Columbia Hotel in Columbia, South Carolina, Friday and Saturday, October 29 and 30. The program will be of general interest to many others who are not members of this organization. In addition, the football game between the University of South Carolina and Maryland will be played that Saturday afternoon and a special section has been reserved on the 50-yard line for doctors attending this meeting.

The interim meeting of the A. M. A. which is to be held in Miami on November 29 to December 3 offers an opportunity for spending a few days in southern Florida and at the same time attending the very best in post-graduate instruction in the country. We hope that a large number of the South Carolina membership can be there.

Tom Gaines

**TEN POINT PROGRAM
OF THE
SOUTH CAROLINA MEDICAL ASSOCIATION**

1. Cooperation

To promote closer cooperation and better understanding between all agencies, groups and individuals concerned with providing and improving medical care for the people of South Carolina.

2. Extension of Medical Care

To study constantly the need and availability of medical care in each county of the State and in the State at large.

To promote plans for providing or improving medical care where is a need, particularly in the rural areas.

3. Pre-Paid Hospital and Medical Care

To make voluntary pre-paid hospital and sickness insurance available to all the people of the State (through Blue Cross, Blue Shield, and commercial insurance policies), and to promote the widespread purchase of such insurance.

4. Care of Indigent

To work with local county and state agencies, and with philanthropic organizations, toward securing good medical care for the indigent.

5. Public Health

To support the South Carolina State Board of Health in its broad program of preventing diseases and of safeguarding the health of our people.

6. Health Councils

To support the State Health Council in its announced program. To sponsor

the formation of a County Health Council in every county of the state, and to encourage our members to support and to work with these organizations.

7. Hospitals

To promote the expansion of present hospital facilities and the building of new hospitals—where there is a definite need.

To strive for highest standards of professional care in the hospitals in the State.

8. Medical Colleges

To support the Medical College of South Carolina and to bend our efforts toward keeping its standards of education on a par with other medical colleges throughout the country.

To promote good nursing education and good nursing care throughout the State.

9. Education of the Public

To acquaint the citizens of the State with regard to the problems of medical care in existence today, to inform them as to what is being done to solve these problems, and to advise with them as to further plans for securing better health and better medical care for the people of South Carolina.

10. Political Medicine

To prevent political control or domination of medical practice or of medical education.

South Carolina Medical Association

1953-1954

C. R. F. Baker, M.D.	Sumter	President
George Dean Johnson, M.D.	Spartanburg	Vice President
Thomas R. Gaines, M.D.	Anderson	President-Elect
Robert Wilson, Jr., M.D.	Charleston	Secretary
J. Howard Stokes, M.D.	Florence	Treasurer
M. L. Meadors	Florence	Executive Secretary and Counsel
Joseph I. Waring, M.D.	Charleston	Editor of Journal
Mrs. Claude G. Watson	Fifth District	Business Manager of Journal

DELEGATES TO A. M. A.

William Weston, Jr., M.D.	Columbia
Julian P. Price, M.D.	Florence

COUNCILORS

First District (Charleston, Colleton, Jasper, Dorchester, Berkeley, Beaufort)	
J. W. Chapman, M.D.	Walterboro, S. C.
Second District (Edgefield, Aiken, Lexington, Richland, Saluda)	
O. B. Mayer, M.D., Chairman	Columbia, S. C.
Third District (Laurens, Newberry, Greenwood, Abbeville, McCormick)	
H. B. Morgan, M.D.	Ware Shoals, S. C.
Fourth District (Anderson, Greenville, Oconee, Pickens)	
Chas. N. Wyatt, M.D.	Greenville
Fifth District (Chester, Kershaw, Lancaster, York, Fairfield)	
R. L. Crawford, M.D.	Lancaster
Sixth District (Florence, Darlington, Chesterfield, Marlboro, Dillon, Marion, Horry)	
J. P. Cain, M.D.	Mullins
Seventh District (Clarendon, Georgetown, Lee, Sumter, Williamsburg)	
A. C. Bozard, M.D.	Manning
Eighth District (Allendale, Bamberg, Barnwell, Calhoun, Hampton, Orangeburg)	
J. H. Gressette, M.D.	Orangeburg
Ninth District (Spartanburg, Union, Cherokee)	
D. L. Smith, M.D.	Spartanburg, S. C.

The Journal

of the

South Carolina Medical Association

VOLUME L

December, 1954

NUMBER 12

Chemotherapy in Tuberculosis

DAVID B. GREGG, M. D.

Charleston, S. C.

Effective chemotherapy is a relatively new field in the treatment of tuberculosis and one in which all practitioners of medicine should take more than passing interest, for the time has about come when it would seem practical for the family physician and general practitioner to assume responsibility for certain phases of the treatment of tuberculosis formerly only undertaken in hospitals—primarily chemotherapy.

In the over half-century period between Koch's discovery of the tubercle bacillus and its identification as the cause of tuberculosis in 1882, and the discovery of streptomycin by Waksman and his co-workers in 1944, the many attempts to find a specific drug had produced only failures and disappointments. Really effective chemotherapy might be said to date from the discovery of streptomycin just 10 years ago. Streptomycin was costly and difficult to produce in quantity, so that it was not until 1946 and 1947 that controlled studies in sufficient numbers were done, mostly by the Veterans Administration, Army and Navy hospitals, to definitely demonstrate the usefulness of streptomycin in human tuberculosis.¹

While demonstrating definitely the suppressive effect of streptomycin, these early studies also brought out two major obstacles to chemotherapy—toxicity and the phenomena of bacterial resistance. In its first employed dosage of 1 to 3 grams daily in divided doses the toxicity of streptomycin was of major proportion. It also soon became apparent that bacilli remaining viable after 6 to 8 weeks exposure to the drug, became resistant to further suppression by streptomycin. Fortunately, during the next several years—

1947 to 1949—studies directed toward the trial of new dosage schedules and with the concomitant use of para-aminosalicylic acid led to two rather surprising discoveries—one, that PAS, an anti-tuberculosis drug of very low order in itself, interfered with the metabolism of the tubercle bacilli in such a manner as to inhibit or even prevent the emergence of resistance to the action of streptomycin given concurrently—And two, that treatment regimens employing streptomycin dosage of 1 gram 2 to 3 times weekly, were as effective as the daily dosage, with the obvious advantage in relief of toxic reactions. Thus in 1950 the combined use of intermittent streptomycin with daily dosage of PAS had become the standard chemotherapy of tuberculosis. This allowed the prolongation of effective chemotherapy, a feature so necessary because of the nature of tuberculosis with so many necrotic lesions requiring prolonged bacterial suppression before healing can take place. Even with this prolongation of treatment, chemotherapy was still considered primarily an adjunctive measure, and rest, collapse measures, and surgical treatment were applied with little modification from their indications prior to chemotherapy.

I am sure you will recall how, early in 1952, the isonicotinic acid hydrazide derivatives were heralded by the newspapers in typical extravaganza style. If it did not live up to its first notices, studies were soon forthcoming to indicate that we had in Isoniazid a drug of potent anti-tuberculosis activity of about the same order as streptomycin.² But the old phenomenon of bacterial resistance was soon found to be evident in patients treated with

Isoniazid alone, perhaps developing more rapidly with this drug than with streptomycin. However, there are indications that with Isoniazid the development of resistance is associated with a decreased virulence of the tubercle bacillus. This was suggested by the fact that patients seemed to maintain the progress made by treatment with Isoniazid after resistance had developed, with the absence of relapse so commonly seen after continuing streptomycin treatment when resistance to that drug had developed. Some investigators even reported that Isoniazid resistant organisms isolated from treated patients were avirulent for the sensitive guinea pig. However, these findings are not uniform and other investigators have failed to confirm them. Until more is learned of this phenomena it is best to disregard it clinically, and since combining Isoniazid with PAS or streptomycin also prevents emergence of resistance, every effort should be made to prevent the development of Isoniazid resistant organisms. For this reason then it is generally accepted that Isoniazid is best not used alone.³

Comparative studies on the effectiveness of combined streptomycin plus PAS, with streptomycin plus Isoniazid, show about equal effectiveness of these two regimens, the Veterans Administration investigators indicating no difference and showing some preference for the streptomycin—PAS perhaps because of proven experience with it, while other investigators felt that there was a slight but consistent, if not a significant advantage in the streptomycin-Isoniazid regime. Early results also indicate that the combination of daily dosage of PAS and Isoniazid is as effective as either of these regimens with the obvious advantage of avoiding parenteral administration, but more time is needed to clearly establish these preliminary reports. Regardless of the results of sensitivity studies, there is much evidence that re-treatment—that is, a second course of treatment, is less effective than initial treatments, and in a disease with the relapsing characteristics of tuberculosis, there is an obvious advantage in not compromising the effect of the really two potent drugs—streptomycin and Isoniazid—by giving them simultaneously if it can be avoided without sacri-

ficing therapeutic results. There are many other factors however, which enter into the decision as to the combination of choice—PAS intolerance being a most common one. As mentioned earlier, the order of anti-tuberculosis activity of PAS being low, high dosage levels are necessary, from 8 to 12 grams daily. As might be expected with oral intake of such order, local irritative manifestations are common—lack of appetite, nausea, vomiting, and diarrhea. These toxic symptoms, though never serious in themselves, are quite disadvantageous when the importance of proper nutrition in tuberculosis is considered. Isoniazid on the other hand is effective in quite low concentration and in its effective dosage range of from 150 to 300 milligrams daily is readily absorbed from the gastro-intestinal tract, making it a rather ideal drug for oral administration. However, the toxic potentialities of Isoniazid are certainly more numerous and of a more serious nature, with the central nervous system being most frequently involved. Such symptoms as restlessness, headache, insomnia, muscle twitching, and hyperreflexia, are fairly common, while the more serious developments such as difficulty in urination, convulsive seizures, and major psychoses, are usually predicated on some preexistent factors. The depression of hemoglobin is common, and rarely agranulocytic reactions and liver damage with jaundice have occurred.

The optimum duration of chemotherapy is at present still undergoing investigation, but it is already apparent that despite the appearance of maximum resolution and dramatic effects of chemotherapy in the early stages of treatment (from 2 to 4 months), beneficial results continue through prolonged treatment for as long as 12 to 18 months. There is also general agreement that treatment should be continuous and uninterrupted with no rest periods or short courses of therapy. The dramatic changes in the early months of chemotherapy are due to the regression of acute exudative disease, the reversible inflammatory portion, but there remains the residual necrotic, caseous and frequently cavitary lesions. With the prolongation of combined chemotherapy it is now well documented that even these lesions also respond

by cavity closure or filling in and contracture and walling off of necrotic and caseous areas. Further, the bacteriologic investigation of these necrotic lesions, after surgical resection following prolonged chemotherapy has failed to reveal viable organisms in a high percentage of cases. These hitherto unexpected results of prolonged treatment marked another milestone and justify the supposition that chemotherapy may well become definitive treatment in many cases.

The institution of prolonged combined regimens has invalidated the former importance of timing chemotherapy with collapse measures and other surgical procedures.³ This has made it practical to begin

chemotherapy on patients when the diagnosis of tuberculosis has been established and not wait until a bed is available in the hospital, often after marked progression of the disease has taken place. In November of 1952, with a long waiting list and time lag of from 4 to 6 months between diagnosis and admission, we began the program of out-patient chemotherapy in the Chest Clinic. Even with Isoniazid alone with the first selective cases the results were most gratifying. The following case reports will best illustrate this:—

Case 1 (A.D.) Colored female diagnosed tuberculosis with positive sputum October 1952. Disease progressed markedly during following month. Patient remained in bed at home as no bed available in hospital. Chemotherapy, consisting of Isoniazid 200 milli-

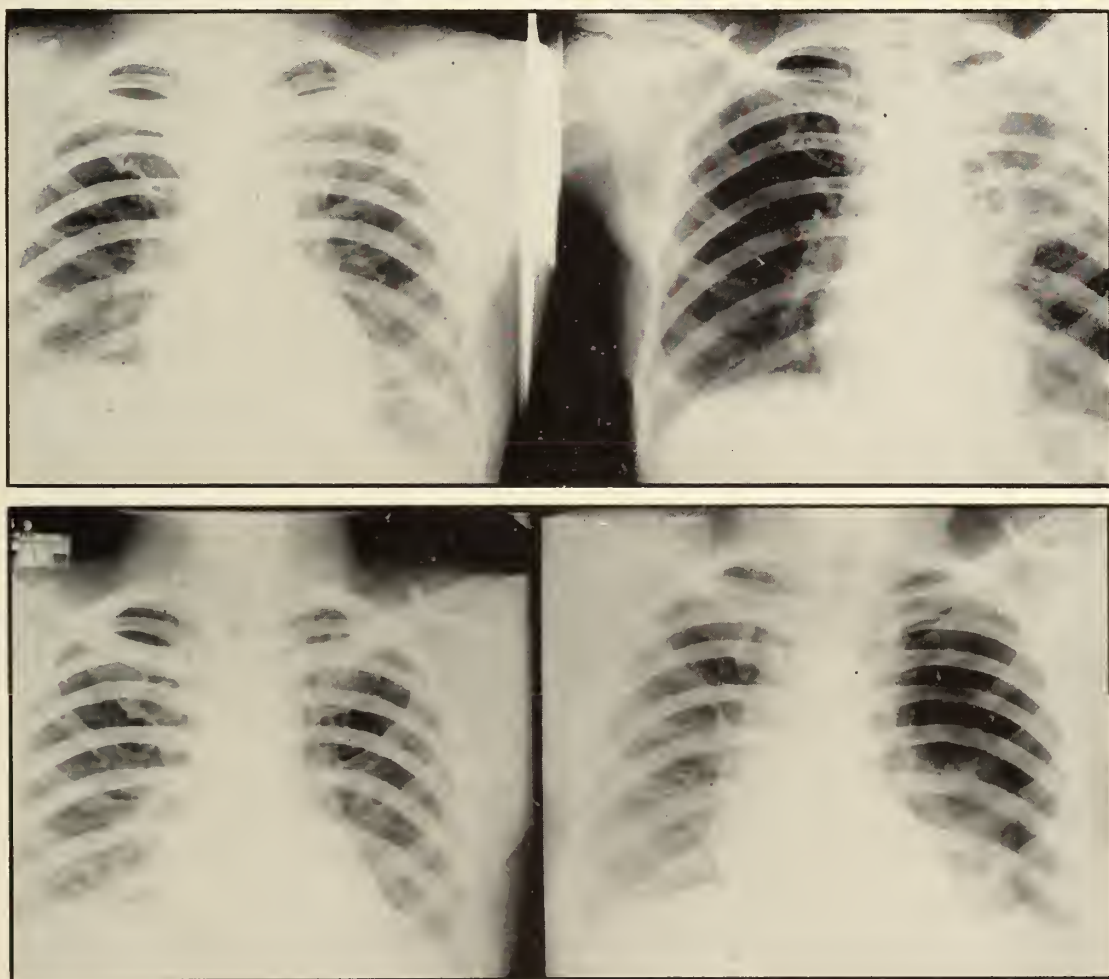


Figure 1

Case 1 (A.D.) P-A Chest Films. Top Left: October 1952 at time of diagnosis—left upper lobe lesion—positive sputum. Top Right: November 1952—marked spread of disease 1 month later while on bed rest at home. Bottom Left: March 1953 at time of admission

to hospital showing marked improvement on 4 months chemotherapy at home. Sputum negative. Bottom Right: October 1953 at time of discharge from hospital showing effective pneumothorax.



Figure II

Case II (M. McM.) P-A Chest Films. Left: January 1953 at time of diagnosis—positive sputum.

Right: January 1954 at time of discharge from hospital, showing resolution of disease with chemotherapy and effective therapeutic pneumoperitoneum.

grams daily, begun in November 1952 with patient remaining at home. There was prompt subsidence of all symptoms and multiple sputum smears were negative in January and February 1953. Admitted to hospital March 1953 with negative sputum smears and cultures. Pneumothorax induced within two weeks after admission. Patient discharged October 1953. Total period of chemotherapy 12 months. Hospitalization only 7 months. (Fig. I)

Case II (M. McC.) Colored female diagnosed tuberculosis in January 1953 with positive sputum. As no bed was available in hospital was treated with Isoniazid—200 milligrams daily. Marked improvement followed with negative sputum smears by March 1953. Despite clinical well-being however, sputum cultures positive in May 1953. Admitted to hospital July 1953 with positive sputum smears. Streptomycin

was begun in addition to Isoniazid after admission and pneumoperitoneum was induced in August 1953. Sputum converted negative again by November 1953. Discharged inactive January 1954. Total period of hospitalization only 6 months. Chemotherapy for 1 year at time of discharge is being continued as well as pneumoperitoneum sustained as out-patient. (Fig. II)

Beyond the objective of reduction of morbidity and even mortality, this program would seem to more than justify itself from a public health standpoint in the early conversion of sputum and the ultimate shorter hospitalization period needed.

In applying prolonged combined treatment to the already hospitalized patient, we are

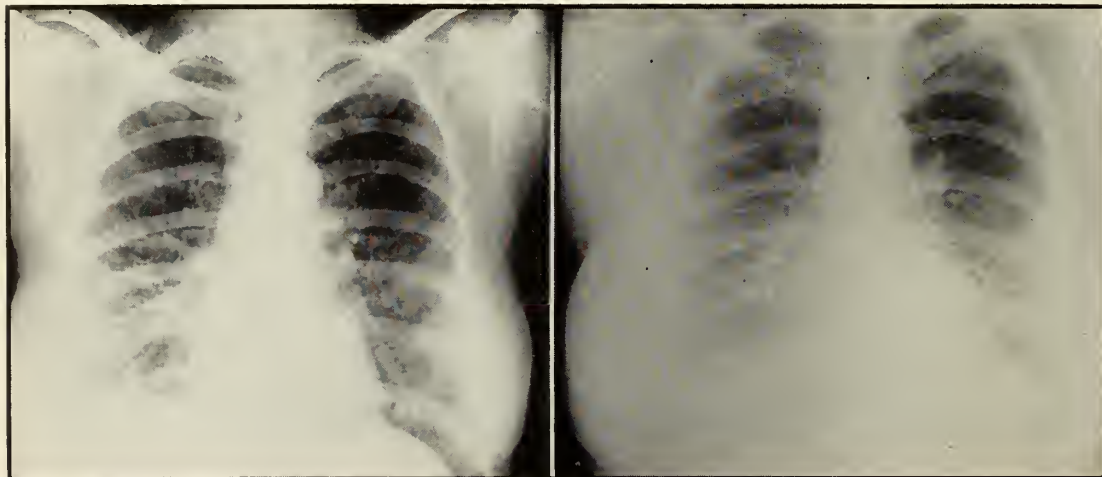


Figure III

Case III (A.J.) P-A Chest Films. Left: April 1953 at time of diagnosis showing miliary tubercles throughout both lung fields.

Right: November 1953 at time of discharge from hospital showing resolution of miliary tubercles.

often faced with the dilemma of retaining in the hospital an apparently well person with stable lesion, non-contagious, and on full exercise, while the waiting list of the acutely ill mounts. Recently to solve this dilemma, we have allowed patients with adequate home facilities to leave the hospital and continue their chemotherapy and modified rest at home. The following Case Report illustrates this:—

Case III (A. J.) White female. Hospitalized March 1946 until January 1947 with pleurisy with effusion. Ten months bed rest only. In August 1952 admitted to a general hospital and had right nephrectomy—tuberculous kidney. Had a short course of chemotherapy when tuberculous etiology of this renal disease was revealed. In April 1953 during a routine follow-up examination found to have miliary hematogenous pulmonary tuberculosis. Was hospitalized promptly. Chemotherapy consisting of streptomycin and Isoniazid begun. With exception of a quite stormy course in first few weeks of treatment patient was completely asymptomatic during hospital stay.

Was discharged November 1953 after 8 months. Chemotherapy is indicated for at least 18 months and will be continued while patient remains at home. (Fig. III)

It is in this phase of the treatment of tuberculosis, and perhaps the prompt institution of treatment prior to hospitalization (until there are no longer waiting lists), that the time has come for the family physician and general practitioner to take part.

REFERENCES

- (1) The Effect of Streptomycin upon Human Tuberculosis. *Amer. Rev. of Tuberc.*—Vol. 56—July-Dec. 1947, P. 485.
- (2) Robitzek, E. H. and Selikoff, I. J. Hydrazine Derivative of Isonicotinic Acid in the Treatment of Active Progressive Caseous-Pneumonic Tuberculosis. *Amer. Rev. of Tuberc.*—Vol. 65, Jan.-June 1952, P. 402
- (3) Chemotherapy of Tuberculosis in Man (Council on Pharmacy and Chemistry). *J. A. M. A.*—Vol. 154, No. 1, P. 52.

Premature Mortality of Roper Hospital

(PERIOD: 1952-1953)

ELIZABETH B. LATHAM, M. D.

Teaching Fellow, Department of Pediatrics,
Medical College of South Carolina and Roper Hospital, Charleston, S. C.

A study has been made of clinical records regarding the immediate outcome of premature infants born at Roper Hospital during the two year period of January 1, 1952, through December 31, 1953. Such a survey has the purpose of serving as a stimulus for reassessment of the routines and techniques employed in the management of premature infants.

The following definition of prematurity, as set forth by the American Academy of Pediatrics in 1935, is still generally used and has been our criterion:¹¹ "A premature infant is one who weighs 2,500 gm. or less at birth (not at admission) regardless of the period of gestation.

"All live-born premature infants should be included, evidence of life being heart beating or breathing."

Analysis has been made of the following aspects of these cases: (1) incidence of prematurity among white and colored hospital

births, (2) mortality rates by standard weight grouping, and (3) time and causes of death.

CLINICAL MATERIAL

All liveborn infants delivered at Roper Hospital in the years 1952 and 1953, weighing five pounds eight ounces (2,500 gm) or less, are included in this study, whether they lived only a few minutes or through the time of discharge. Any death occurring after discharge from the nursery is not considered here.

There were 4,741 live births, 369 of which were premature live births, the latter comprising the material used for the study. This group is made up of white and colored, private and service cases, with the colored infants far surpassing the white in number (ratio of 2.9:1). Those transferred from home, or from other hospitals, to this hospital for premature care are not included in this appraisal.

For study of the causes of death, only autopsied cases are considered; autopsy rate was 84.78%. When a clinical impression, only,

was recorded as the cause of death, the death was simply counted in the "no autopsy" category. The cause of death for each infant in our study was accepted in the light of the combination autopsy and clinical impressions.

RESULTS

An overall incidence of prematurity of 7.78% was found (see table I), with the unusually high incidence of 9.92% in the colored infants. Only 93 of 369 prematures were white, giving an incidence of 4.74%. There were more white infants in the higher weight groups; 82.8% had a birth weight of 1501 gm. (3 pounds 4 ounces) or more; 78.9% of the Negro infants were in the higher weight group.

There was an overall sex incidence of 50.6% females, and 49.4% males. Of the 93 white prematures, 49 (53.6%) were females; of the 276 colored prematures, 138 (50.0%) were females.

The overall fatality rate was 24.9% (25.8% for white and 24.6% for colored prematures), since a total of 92 of the 369 prematures died (see table II). Survival was poorest among the lower weight groups (see table II and III), there being a fairly large number of "1000 gm. or less" infants, those named by some authors as the "nonviable" or "previable" group^{6, 13, 17}.

Immaturity, birth injury, and infection, in that order of frequency, were the most significant causes of death in our series of cases (see table IV). The term "immaturity", includes incomplete development to the extent of probable incompatibility with extrauterine existence. It also includes failure of expansion of the lungs and anoxia due to the latter condition. Intracranial hemorrhage is included with birth injury because in several cases, it was impossible to determine at autopsy, whether hemorrhage was due to birth trauma or to a localized manifestation of hemorrhagic disease of the newborn. Congenital anomaly was given as the cause of death only in cases where the defect was severe enough to be incompatible with life. Infection is represented by cases of bacterial meningitis, pneumonia (of probable bacterial etiology), and one case of bacteremia. Next in order of frequency of occurrence was aspiration.

For the most part, deaths due to immaturity and birth injury occurred within the first 24 hours following delivery. All deaths due to infection took place after age 48 hours.

DISCUSSION

The overall incidence of prematurity at Roper Hospital, 7.78%, compares unfavorably with the national average of approximately 5% in 1944,⁷ and 6.1% in 1946 (a figure obtained after compilation of statistics from 193 hospitals in the United States, the information concerning the year 1946 for the most part).¹

Our high incidence might be explained by two major factors, one being the heavy service patient load; therefore, most of the mothers were of the lower socio-economic bracket in which prematurity always occurs more frequently.^{2, 6, 7, 13} The second major factor is that Negro prematures in our group of cases out-number white prematures by a ratio of 2.9:1. It has been shown in numerous previous studies^{4, 7, 15} that there is a higher incidence of prematurity in the Negro race, a higher incidence of low birth weight and also, that mortality rates are higher among Negro prematures. This study shows that the 1952 and 1953 mortality rate for colored prematures at Roper was 24.6%, which is better than the white mortality rate, which was 25.8%.

The well-founded adage of premature survival being commensurate with birth weight, varying directly, is borne out by our statistics (see table III). By comparison with estimates of survival percentages established by the Children's Bureau (1948), our premature salvage is seen to be disappointingly small, as is the experience in other parts of the country.

EXPECTED PREMATURE SURVIVAL

Wt. in Grams	Roper's Percentage	Children's Bureau Estimate (%), 1948
0 - 1000	5.6	0
1001 - 1500	47.4	50
1501 - 2000	72.0	82
2001 - 2500	95.4	93

Our principal causes of death other than prematurity itself, were intracranial hemorrhage (which indicates a need of more thoughtful conduct of labor and delivery when a premature is expected), and infection (which serves as a vote in favor of more liberal

use of prophylactic antibiotics, since only two of those dying of infection had received antibiotics).

The subject of conduct of labor, in cases where prematurity is anticipated, has received much scrutiny and investigative work^{7, 8, 9, 15, 16 & 18}. The following obstetrical principles have proved themselves worthwhile in lowering premature mortality:

- Avoidance of precipitate first stage of labor
- Minimal if any analgesia
- Conduction anesthesia
- Generous episiotomy
- Outlet forceps

Forty-seven (51.0%) of the 92 premature deaths occurred within the first 24 hours following birth; this suggests that pre- and intranatal factors are still to be surmounted. Prevention of prematurity is the desirable objective, and throughout the country, educational and prenatal care programs with this in mind have been increasingly effective.⁶

Because infection was the outstanding cause of death among prematures living beyond 48 hours and because these are theoretically preventable deaths, the need for prophylactic antibiotic therapy (where indicated) is brought vividly to mind. However, two of the infants who died of pneumonia, presumably bacterial, had been given an oral broad spectrum antibiotic prophylactically. As one British author has said,⁵ by the time of autopsy, it is sometimes difficult "to pick the cause of death out of the effects of dying". In these cases, bacterial invasion of the respiratory tree could well have occurred terminally, the fundamental cause of death remaining obscure.

The service patients delivered at Roper Hospital with a birth weight of five pounds (2270 gm.) or more, are placed in the full term nurseries, while those weighing less are cared for in the premature nurseries. Gordon-Armstrong Incubators and Isolettes[®] are used, the latter being employed for the smallest prematures. Ideally, provision is made for immediate removal of mucus, maintenance of body temperature, oxygen administration, and additional measures as indicated. Oxygen, humid-

ity and wetting agent (either Alevaire[®] or 0.05% sodium lauryl sulfate with 3% glycerine solution) are supplied in the form of mist, via Vapojet[®] attachment to the Isolettes, or else generated in a deVilbiss No. 40 nebulizer by an oxygen flow of eight liters per minute. The Rockette[®] resuscitator has also been used for a short period of time with some success.

Oral feedings are administered cautiously according to the usual schedules for prematures, gavage feedings by polyethylene tubing are used rather effectively in the smaller prematures (all service cases and some private cases). The method of administration of feedings is decided by the size and condition of each individual patient, and feedings are supplemented as needed with parenteral fluid therapy.

Antibiotics are given those prematures who had any type respiratory difficulty at the time of birth, those delivered by Cesarean section, those delivered under circumstances considered for some reason to be "contaminated", and very small prematures.

As stressed repeatedly by authorities in the field of premature care, interested and trained nursing personnel constitutes a tremendous asset to any premature nursery. Unfortunately, nurses working in our nurseries have received no special training in the handling of prematures. Student nurses without previous pediatric or nursery experience are sometimes left in charge of the colored nursery because of the shortage of nurses. Another disadvantage is that the nursing staff appears to be changing constantly. It is possible that closer observation may have prevented some of the deaths due to aspiration.

The compiling of data such as these statistics, leads to critical self-examination which is desirable if steps can follow to correct or minimize our deficits. Further, the need for accurate premature records and carefully carried out autopsies on prematures is made more evident by such statistical analysis.

Dunham^{6, 7} points out the importance of "comparisons between hospitals and between periods", with uniformity of statistics recording. A form for recording information on prematures has been suggested, as well as the following three point plan:

*Made by Air-Shields, Inc., Hathoro, Pa.

**Made by Winthrop-Stearnes.

1. "Include in statistics all live-born infants weighing 2,500 gm. (5 lb. 8 oz.) or less, regardless of gestation period. No exclusions should be made on the basis of "nonviability". Arbitrary exclusions should not be made on the basis of low birth weight or birth length, gestation period or duration of life.

2. "Compile data for the total number of premature infants who are born alive and the total who die according to the birth-weight groups recommended in the resolution adopted by the American Academy of Pediatrics.

3. "Compile data (A) for infants born in the hospital separately from those admitted to the hospital after birth; (B) by race—white, Negro, other—for the totals and the birth-weight groups."

The data in table V, obtained from various references, yielded a comparison for our statistics on incidence and mortality rates of prematures. It should be noted that some studies consisted of private patients only, or "white infants only", and therefore, cannot be used unreservedly for purposes of comparison. It is believed that Roper Hospital premature statistics are unusually good, considering the not

altogether favorable conditions under which prematures are managed.

SUMMARY

The incidence of prematurity at Roper Hospital during the period 1952-1953 was found to be 7.78% (white, 4.74% and colored, 9.92%). The overall mortality rate of premature infants was 24.9%; broken down into the standard weight groups, our mortality figures are seen to be comparable with those found in other parts of the country. The causes of death were chiefly immaturity, birth injury, and infection, in that order of frequency.

The problem of bettering our premature infant mortality statistics rests upon the following tripod: (1) prevention—therefore the realm of the obstetrician and public health department; (2) ready, immediate provision of optimal environmental conditions and management—the realm of the pediatrician; and (3), interested and trained round-the-clock observation and care—the realm of the nurse. Thus, teamwork and cooperative study will yield the most effective management of the problem of prematurity.

TABLE I
Incidence of Prematurity, Roper Hospital, 1952-1953

	White	Colored	Total
No. of Newborns (Live Births)	1,961	2,780	4,741
No. of Premature Newborns (Live Births)	93	276	369
Incidence of Prematurity	4.74%	9.92%	7.78%

TABLE II
Premature Mortality Statistics, Roper Hospital 1952-1953

Birth Weight In Gms. & Lbs.	Liveborn Prematures			Number of Deaths			Mortality Rate		
	White	Col.	Total	White	Col.	Total	White	Col.	Total
1000 gm. or less (2 lb. 3 oz. or less)	8	28	36	8	26	34	100%	92.8%	94.4%
1001-1500 gm. (2 lb. 3 oz.— 3 lb. 4 oz.)	8	30	38	4	17	21	50.0%	56.6%	52.6%
1501-2000 gm. (3 lb. 4 oz.— 4 lb. 7 oz.)	23	77	100	7	21	28	30.4%	27.2%	28.0%
2001-2500 gm. (4 lb. 7 oz.— 5 lb. 8 oz.)	54	141	195	5	4	9	9.2%	3.5%	4.6%
TOTAL	93	276	369	24	68	92	25.8%	24.6%	24.9%

TABLE III
Roper Premature Mortality by Birth Weight Groups

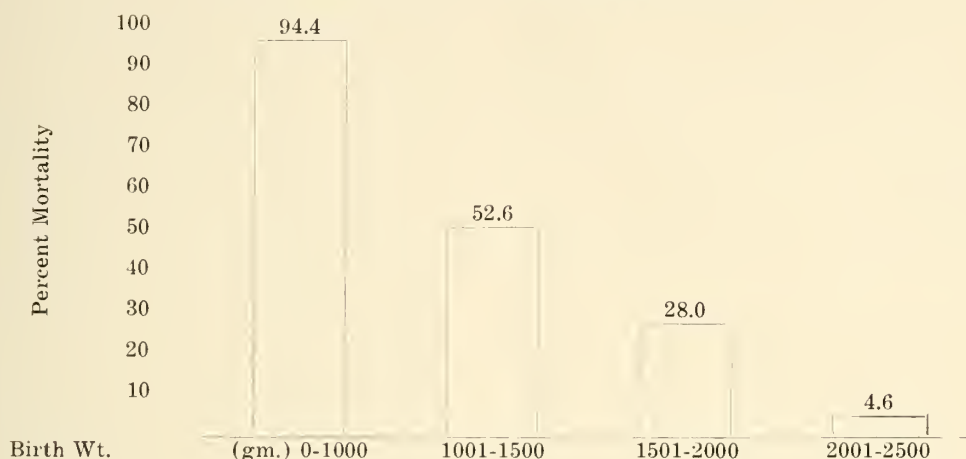


TABLE IV
Cause of Death by Age 1952-1953
(Autopsy Rate 84.78%)

Cause of Death	Under 24 Hrs.	24-48 Hrs.	Over 48 Hrs.	Total
Immaturity (including incomplete expansion of lungs)	24	6	6	36
Birth Injury (and intracranial hemorrhage)	10	2	2	14
Congenital Anomalies	2	2	1	5
Infection	0	0	12	12
Aspiration	0	1	6	7
Peptic Ulcer	0	0	1	1
Hyaline Membrane Dis.	0	1	1	2
Erythroblastosis	0	0	1	1
No Autopsy	11	1	2	14
TOTAL	47	13	32	92

TABLE V
Premature Statistics From Various Hospitals

Hospital	Years Covered	Incidence %	Mortality Rate %
Children's Bureau Estimate ¹	1946 mainly	6.1	21.5
Northwestern University Medical School ^{18*}	1941-1950	5.45	20
Philadelphia Lying-In ¹⁷	1930-1944	9.4	38.5
Bridgeport (Conn.) Hospital ^{3*}	1947-1949	7.0	21
Geisinger Memorial (Danville, Pa.) ^{12*}	1938-1942	7.42	20.4
St. John's (Tulsa, Okla.) ^{13*}	1941-1950	6.8	22.4
Johns Hopkins University ⁸	June 1926-1945	11.7	24.1
Walter Reed Army Hospital ¹⁴	March '48-July '52	8.9	14
Roper Hospital	1952-1953	7.78	24.9

*Mostly private, white patients. The Bridgeport report includes infants with birth weight of 2270 Gm. (5 lbs.) or less only.

BIBLIOGRAPHY

1. Bain, K.; Hubbard, J. P.; and Pennell, M. Y.: "Hospital Fatality Rates for Premature Infants," *Ped.*, 4:454, Oct. 1949.
2. Bloch, H.; Lippsett, H.; Redner, B.; and Hirschl, Daniel: "Reduction of Mortality in the Premature Nursery, Incidence and Causes of Prematurity: Ethnic, Socioeconomic and Obstetric Factors", *J. Pediat.* 41:300, Sept. 1952.
3. Bogin, M.; and Edgar, K. J.: "Statistical Study of the Premature Infant", *Conn. State Med. Jour.* 15:569, July 1951.
4. Crump, E. P.; Wilson-Webb, C.; and Pointer, M. B.: "Prematurity in the Negro Infant; A Study of Patients Admitted to the George W. Hubbard Hospital Nurseries During an Eleven-year Period", *Amer. Jour. Dis. of Child.*, 83:463, April 1952.
5. Discussion, "Some Problems of Prematurity", Section of Pediatrics, *Proc. of the Royal Society of Med.*, 46:880, March 27, 1953.
6. Dunham, E. C.: "Factors Associated with Reduction of Premature Infant Mortality Rates in the United States", *J. Pediat.*, 41:697, Dec. 1952.
7. Dunham, E. C.: *Premature Infants, A Manual for Physicians*, Federal Security Agency, Children's Bureau Publications No. 525, 1948.
8. Eastman, N. J.: "Prematurity From the Viewpoint of the Obstetrician", *Amer. Practitioner* 1:343, March 1947.
9. Peckham, C. H.: *Statistical Studies on Prematurity, "Incidence of Prematurity and Effect of Certain Obstetric Factors"*, *J. Pediat.*, 13:474, Oct. 1938.
10. Plattner, E. B.; Stein, A. F.; and Gerber, H. X.: "Analysis of Premature Mortality Rates", *Ped.* 5:193, Feb. 1950.
11. *Proceedings, Fifth Annual Meeting of the American Academy of Pediatrics*, New York City, June 7, 1935, Round-table Discussion on Prematurity, *J. Pediat.*, 8:104, Jan. 1936.
12. Ritmiller, L. F.; and Nicodemus, R. E.: "An Analysis of a Five-year Incidence of Premature Births", *Penn. Med. Jour.*, 47:690, April 1944.
13. Russell, G. R.; and Betts, W. A.: "Natal and Neonatal Factors in Premature Infant Mortality", *J. Pediat.* 40:722, June 1952.
14. Smith, A. G.; and Bruton, O. C.: "A Study of Premature Infants", *U. S. Armed Forces Med. Jour.* 4:1279, Sept. 1953.
15. Taback, M.: "Birth Weight and Length of Gestation with Relation to Prematurity", *Journal of American Medical Association* 146:897, July 7, 1951.
16. Taylor, E. S.; Phalen, J. R.; and Dyer, H. L.: "Effect of Obstetric Difficulties and Maternal Disease on Premature Infant Mortality", *Journal of the American Medical Association*, 141:904, Nov. 26, 1949.
17. Tyson, R. M.: "A Fifteen-year Study of Prematurity", *Journal of Pediatrics* 28:648, June 1946.
18. West, R. H.; Grier, R. M.; and Lussky, H. O.: "Premature Infant Mortality", *American Journal of Obstetrics and Gynecology* 64:1222, Dec. 1952.

Rambling With An Anesthesiologist Through Judicial Decisions of South Carolina

FRANK H. BAILEY, LL.B

Charleston

It has been rather pleasant and entertaining to review in the past few weeks, at random, the reported judicial decisions of our South Carolina Courts pertaining to the medical profession in this State.

Apparently, the first officially reported opinion is to be found in Brevard's and in Treadway's Reports, of the Constitutional Court, held at Columbia, in November 1815, in the case of Dr. John Hughes vs. General Wade Hampton, 3 Brev. 544, 5 S. C. Law 261, and 2 Tread. Const. 745, 7 S. C. 74.

Dr. Hughes brought an action against General Hampton for the payment of a bill presented for medicines and medical attendance. The lower court found judgment for the physician. On appeal, the Court in granting a new trial, said:

"The charges were general ones for medicine and attendance. One item was '13 dollars for medicine and attendance on one of the General's daughters, in curing the whooping cough.' The new trial is asked, on the ground that the plaintiff ought to have given a specific bill of the medicine and attendance."

Thus the Court held that the charges were too general.

In the annals of the Constitutional Court, May 1818, in the case of Brown vs.. Mims, 2 Mills Const. 235 (9 S. C. Law 62), involving an action for slander, it appears that a Mr. Mims was discussing Dr. Brown with a lady and asked her in conversation what she thought of him. She replied that she thought very highly of Dr. Brown, that he had been very successful in his practice, and was much

esteemed in the district. Mims said that he thought "that he was damned rascal, and not fit to give medicine to a puppy, and that he should not give medicine to a sick puppy of his." Dr. Brown heard of the publication of what had been said, sued Mims and a jury awarded him a verdict of \$200.

An appeal from the judgment was made on the ground that the words were not in themselves actionable, and there was nothing in the declaration from which it could be inferred that they related to the skill of his profession.

Justice David Johnson, delivering the opinion which affirmed the judgment of the lower court, said that the words spoken in the conversation were an imputation against the professional skill of Dr. Brown. That the words "he was damned rascal," although a vulgar expression, was, perhaps, the strongest in use, to convey our ideas of moral turpitude, and rebutted the lady's opinion of his good character; those which followed were, therefore, unnecessary to explain his meaning on that subject, and must have been intended to apply to his success in the practice of physic, and can mean nothing else than a want of skill.

One judge of Court dissented from the opinion; therefore, you are at liberty to draw your own conclusions of what he thought of Dr. Brown.

It is interesting to note in the dicta of the case that Judge Johnson says "every thinking man must rejoice that the Legislature, at their last session (1817), have adopted measures to regulate admission to practice physic. But, until now, reputation and merit were generally considered sufficient to entitle the possessor to the appellation of physician, and many, without any other badge of profession, have, and continue to be, ornaments to the profession, and country in which they live; and the health and life of the citizen has frequently been found more secure in their hands than in the hands of those who have no other claim to confidence than the bare possession of a diploma."

Thus we see that in 1817, 137 years ago, the State of South Carolina was interested in the welfare of her people, and was ready to extend protection of the law against those who would

betray the ethics of the medical profession.

And in the Constitutional Court sitting at Charleston, in 1821, *McBride vs. Watts*, 1 McCord, 384 (12 S. C. Law 156), we learn that a Dr. McBride had attended and provided medicines for a mate on a ship while he was ill of a fever in the port of Charleston. Dr. McBride presented his bill for services and, before it was paid, he passed away. Thereafter, his widow, as executrix of his estate, brought action against the owner of the vessel for payment. Upon trial of the case, in support of the bills, Dr. McBride's original book of entries was produced and proved, and a witness testified that the physician had tendered the bill to Captain Watts, owner of the vessel, who had made no objection. The judgment in the lower court was for payment of bill.

The Judge ruled that the doctor's books of original entries was good evidence, both as to the medicine administered and of the person who engaged his services, upon authority that the Court had determined that the books of a shop keeper were *prima facie* evidence, both as to sale and delivery; and that the court had held an entry made by a servant of a tailor who had died was good evidence as to sale, although there was no proof as to delivery. That the Captain of the vessel was liable in that there was a tacit admission on his part that he had employed the doctor and, under the ancient marine law the captain was bound to provide everything necessary for the mate's recovery.

Here we see that the shop keeper and tailor have been of benefit to the medical profession in establishing that your records are good evidence, and that your nurse or assistant may make them for you, and which may be competent evidence. I may add that the Judge in the Brown case, *supra*, who said it was not slander to call a physician a "damned rascal," agreed that the late Dr. McBride was entitled to be paid for his services.

In 1847, a surgeon brought suit against a general practitioner, to collect his fee, *Guerard vs. Jenkins*, 1 Strob. 171 (32 S. C. L. 75). Dr. Jenkins was the retained physician for a plantation near Charleston. One of the slaves on the plantation became very ill and it was determined that a surgical operation was

necessary. Dr. Jenkins directed the overseer to send for Dr. Guerard, a surgeon of Charleston, who performed the operation, without any assistance from Dr. Jenkins. Dr. Guerard presented his bill to Dr. Jenkins, who refused to pay it, so he brought action to recover his fee of \$50. The Judge of the lower court decreed that Dr. Jenkins should pay. He appealed on the grounds that there was no privity of contract between the two doctors, and that the services were rendered to the plantation.

The Court of Appeals, in sending the case back for a new trial, held that in an action on parole contract, it was necessary to aver that the consideration was performed at the special instance and request of Dr. Jenkins and he had derived no benefit from Dr. Guerard's professional services to the slave of the plantation owner, from which a previous request may be implied, nor did he promise to pay for them. That in order to charge Dr. Jenkins with an implied promise, it would be necessary to prove that the services were rendered at his request. He did not authorize the overseer to send for the plaintiff on his account or in his name, nor did he assume to pay for services. The case seems to imply from testimony given by a witness, who was a physician, that if a physician calls another in consultation, without the knowledge of the owner, "the usage would be to charge him who requested the consultation."

In referring to the slander case of Dr. Brown vs. Mims, *supra*, mention was made to the Court's comment in regard to the General Assembly taking action in 1817 to regulate the practice of medicine in South Carolina.

In 1859, we find the Act of 1817 playing an important part in the case of Crane vs. McLaw, 12 Rich. 129 (46 S. C. L. 43).

Dr. Crane, of Columbia, brought action against McLaw for the payment of a bill rendered for medicine and medical services. He proved the account from entries in his book, and stated he was a practicing physician. The defendant insisted that the doctor should produce his license to practice physic and surgery before he be allowed to prove his account, and moved for a non suit. The Judge overruled the motion and decreed judgment for the doctor.

The Court of Appeals, in dismissing the ap-

peal before it, referred to the Act of 1817, the fourth section of which was to the effect that a physician had to be licensed under the laws of South Carolina to legally collect payment for his services. The Court observed that prior to 1817, he who employed a physician and accepted his services, *prima facie*, admitted his professional qualifications, and that the court had considered the Act of 1817, in *Westmoreland vs. Bragg*, 2 Hill 414, where an apothecary who had no license could not recover a debt for "vending liquids compounded of roots and vegetables according to the Thompsonian system."

The Court came to the conclusion that for a physician in South Carolina to collect a fee, he must be licensed, and that the person sued had a right to require production of such license, however, the person claiming that the physician had no license, must give reasonable notice by plea or otherwise that he produce it. There being no notice or plea in the cause, Dr. Crane recovered.

Now in 1882, in *Barnwell County, Hyrne vs. Erwin*, 23 S. C. 226, we find that a Mr. Hyrne brought an action against Dr. J. D. Erwin and Dr. C. W. Erwin, father and son, partners in the practice of medicine, to recover \$5,000 for negligent and unskilful conduct in the setting and treatment of his arm.

Mr. Hyrne had his arm broken by the falling of his horse, and the physicians were called and both attended him. He alleged that there was negligence in setting his arm, in applying the bandages too tightly, failure of the doctors to give attention to him, when requested, and not returning for several days, and as a result he lost the use of his arm. There was a jury trial, with a verdict of \$1,000 as damages. From the judgment, the physicians appealed to the Supreme Court on the charges of law given by the trial judge. The Court, in affirming the judgment, said in effect that partners in the practice of medicine are all liable for an injury to a patient resulting from the negligence, either of omission or commission, of any one of the partners within the scope of their partnership, but for an injury resulting from the act of one partner outside of the common business, the offending partner is alone responsible. This is based on the general doctrine

of agency and of relation of master and servant.

The higher Court found no error in the charge of the trial judge, in saying "that when two gentlemen associate themselves together in the practice of medicine or law, or any other scientific profession, each becomes surety for the other that he will faithfully and properly perform his engagements. And if either fail to display reasonable care, diligence and skill in the performance of his duties, both are liable."

The matter of regulating the practice of medicine is of great importance to State, welfare of the public, and physicians alike. In 1888 we find in the case of *Robb vs. State Board of Medical Examiners*, 6 S. E. 824, 28 S. C. 589, where a doctor sought to have the Board admit him to practice in this State, and was refused a license. A brief analysis is given of the different acts between 1817 (*Brown vs. Mims* — 2 Mills Const. 235 — slander case) and 1888 by Judge C. J. Simpson which reflect that,

From 1817 to 1829 physicians and surgeons could be licensed in this State by one of two boards (one at Charleston and the other at Columbia) either upon examination where the applicant had no diploma, or without examination, where he had a diploma.

From 1828 to 1833 a diploma was required, or an examination by the faculty of the Medical College of Charleston.

From 1833 to 1869 the trustees and faculty of the Medical College of the State could alone grant license, which it was authorized to do upon presentation of a diploma from some medical institution, or, in its absence, upon examination by and a recommendation from said faculty.

From 1869 to 1881 two full courses of instruction and graduation at some school of medicine, either in the United States or some foreign country, or a certificate from some state medical society.

From 1881 to 1887, all physicians and surgeons were required to register in the Clerk of Court's office in the County in which he practiced.

In 1887 the "State Board of Medical Examiners" was created, vested with power to ex-

amine such persons if deemed necessary; license to grant or not as the board may determine.

In 1902, *Moore vs. Napier*, 42 S. E. 997, 64 S. C. 564, a student was graduated and received a diploma from the South Carolina Medical College, having studied the course for three (3) years. When he matriculated, the course of study established for graduation was only three years; but while at the institution a four-year course was inaugurated, commencing with the collegiate year of 1901.

Under the statutory law of the State, while this young man was attending the Medical College, it was provided that those who desired to practice medicine in the State were to present certain data, credentials and qualifications to the State Board of Medical Examiners and, upon passing an examination given by the Board, a license was granted. On February 15, 1901, the law was amended so as to provide that the section was not applicable to a regular graduate, holding a diploma issued by any medical college of the State, which had a four year course.

When the young and enterprising student received his diploma, he immediately made application to the State Board of Medical Examiners and requested his license, contending that he had received a diploma from the South Carolina Medical College and was entitled to his license. The Board turned him down. He then made application for a writ of mandamus to the Supreme Court to Order the Board to give him his license.

The Court sustained the Board, and held that the young man was not entitled to a certificate to practice without an examination.

There are many other cases involving the authority of the State Board of Medical Examiners and the regulation of the "practice of medicine" in South Carolina, (*Hollis vs. Board*, 64 S. E. 232, 82 S. C. 230; *Harris vs. Sims et al.*, State Board of Dental Examiners, 109 S. E. 411, 118 S. C. 1; *State vs. Barnes*, 112 S. E. 62, 119 S. C. 213—Chiropractor; *State vs. Deadwyler*, 130 S. E. 332, 133 S. C. 75—Chiropractor; *Ex Parte Oliver*, 134 S. E. 657—not reported in State Reports; *Gregory vs. MeInnis*, 134 S. E. 527, 140 S. C. 52—defines malpractice as to veterinarian; *Ezell vs. Ritholz*,

198 S. E. 419, 188 S. C. 39—optometry; South Carolina State Board of Dental Examiners vs. Breeland, 38 S. E. 2d 644, 208 S. C. 469, 167 A. L. R. 221; Lake vs. Mercer, 58 S. E. 2d 336, 216 S. C. 391—chiropractor; Jacoby vs. South Carolina State Board of Naturopathic Examiners, 64 S. E. 2d 138, 219 S. C. 66; Williams vs. Capital Life and Health Ins. Co., 41 S. E. 2d 208, 209 S. C. 512—an osteopath, a homeopath, a chiropractor, a magnetic healer and a naturopath are alike, practitioners of medicine)

A leading case in this State involving malpractice is that of Dillishaw vs. Bell, 105 S. E. 410, 115 S. C. 258, from McCormick County, in 1920.

Mrs. Dillishaw was the mother of several children, and, on October 26, 1917, she arose to attend to the wants of one of them. In some way she fell to the floor and injured her knee. Dr. Bell was called to attend her. He came, made an examination and found the knee was too painful to make a thorough examination and, not having brought an anaesthetic with him, went away to get it. He returned the same night with Dr. Mattison to assist him. When these two doctors had made an examination, they agreed that the injury was the result of a torn muscle and not a broken kneecap or patella. The physicians bound up the knee with a bandage known as a "figure 8" bandage. The knee did not get well and Mrs. Dillishaw called in Dr. Fuller, whose diagnosis was a broken patella. Dr. Fuller called to his assistance Dr. Neel, who was doubtful as to the diagnosis. An x-ray was taken, and it confirmed the diagnosis of Dr. Fuller. Months later, Dr. Fuller and Dr. Neel performed a surgical operation on the knee which was successful. Dr. Bell quit the case when Dr. Fuller was called.

Mrs. Dillishaw brought action against Dr. Bell for negligent treatment, alleging three specifications of negligence, to wit: Negligence in making the diagnosis, negligence in the treatment, and negligence in a premature discharge of the plaintiff as cured. The jury returned a verdict in her favor. The doctor appealed from the judgment to the Supreme Court on the ground that a verdict should have been directed in his favor. That is, that the

evidence presented did not show negligence on his part.

The Supreme Court, in reversing the judgment of lower Court, decreed that a verdict should have been directed for Dr. Bell.

The Court said,

As to Negligence in the Diagnosis;

"The strongest point in the plaintiff's (Mrs. Dillishaw) favor was the statement that there was an indentation on the knee that followed the break in the bone, and large enough to hold the finger. There was undisputed evidence, however, that a torn muscle would have produced the same depression. The evidence is all one-way—that an injured knee presents difficulties of diagnosis that mislead the most skilful physicians." That negligence in a diagnosis goes out of a case when it is the uncontradicted testimony that a mistake in the diagnosis of injury to a knee is liable to occur with the most skilful.

As to negligence in treatment;

"All the doctors said that the "figure 8" bandage was a well recognized method of treating this kind of injury, when the patella was broken. It may be better to operate, but even operations are not always successful. There is no evidence from which negligence in treatment can be inferred."

As to premature dismissal;

Dr. Bell said that he quit the case when he learned that Dr. Fuller had been called in, and that was the practice. And the Court held that there was insufficient evidence to submit to the jury as to whether Dr. Bell prematurely dismissed the case.

Digressing from our State decisions for a moment, it is needless to say that a physician abhors the word "malpractice," which is defined in 70 C. J. S. 175 as being bad or unskilful practice on the part of a physician or surgeon resulting in injury to his patient. For a moment we shall discuss generally the duty and liability of an anaesthesiologist toward a patient.

It is the duty of an attending physician or surgeon to use reasonable skill and care for the safety and well-being of his patients. In the absence of any statute, the common law holds every physician or surgeon answerable for an injury to his patient resulting from want

of the requisite knowledge and skill or the omission to use reasonable care and diligence, or the failure to exercise his best judgment. 41 Am. Jur. 198.

The duty of a physician or surgeon to bring skill and care to the amelioration of the condition of his patient does not arise from contract, but has its foundation in public considerations which are inseparable from the nature and exercise of his calling. It is predicated by the law on the relation which exists between physician and patient. *Nat'l San vs. Ward*, 100 U. S. 195, 25 L. Ed. 621.

Perhaps you will say that when rendering medical aid the patient should give full cooperation, and he should, as it is the duty of the patient to submit to the treatment prescribed by his physician and follow directions given by him. If the patient fails to do so and thereby enhances or aggravates the injury, the rule seems to be universal that such disobedience will prevent a recovery in a malpractice action. *Jenkins vs. Charleston General Hospital & Training School*, 90 W. Va. 230, 110 S. E. 560. This is known as contributory negligence or assumption of risk on the part of the patient.

A physician must possess that reasonable degree of learning, skill and experience which ordinarily is possessed by others of his profession under similar circumstances. It does not exact the utmost degree of care and skill attainable or known to the profession. His conduct is subjected to a test by a reasonable external standard. 41 Am. Jur. 201.

Likewise, it is the accepted rule that a physician who holds himself out to be a specialist is bound to bring to the discharge of his professional duties as a specialist that degree of skill, care and learning ordinarily possessed by specialists of a similar class, having regard to the existing state of knowledge in medicine in his special field, that is, a higher degree of skill, care, and learning than that of the average practitioner. If he holds himself out as such, he must bring to his patients that degree of skill which a specialist assumes to possess. 41 Am. Jur. 208.

The duty and liability of a physician in administering an anesthetic to a patient are substantially the same as those which govern him

in treating a patient generally. That is, he is bound to exercise such reasonable care and skill in that behalf as is usually exercised by average physicians or surgeons of good standing in the community in which he practices. 41 Am. Jur. 212.

Under related decisions it would appear that an anesthesiologist, being a specialist, is charged with the duty of acting on his bona fide judgment and is not liable for injuries or death resulting without negligence, from honest errors of judgment. He is liable, however, if his mistake of judgment is so gross as to constitute negligence.

He may be liable if he fails to observe plain physical laws or physical facts which are governed by ordinary principles of intelligence. That is, if he persists in administering an anesthetic after a warning which would impel one of reasonable prudence to desist, he should be answerable for the consequences.

It has been held negligence for an anesthesiologist to administer a certain anesthetic without first advising himself by an examination as to the condition of the patient. 12 A. L. R. 1494.

The question may be promoted as to what is the liability of an anesthesiologist for the negligence of the operating surgeon.

A physician or surgeon must exercise due care in selecting his assistants, and on the simplest principles of law, agency, or of master and servant, a surgeon may be liable for the neglect or fault of his employee or servant, such as an assistant who is working under his direction for injury resulting therefrom to a patient.

Frankly, our Courts are divided as to the liability of an operating surgeon for the negligence of an anesthesiologist of his choice. Generally the rule of master and servant exists and the doctrine of respondent superior applies. Where the surgeon directs the anesthetist, he is responsible for his acts, for the surgeon is in control and the act of his assistant is the act of the surgeon. 60 A. L. R. 149.

It is reasonably safe to conclude from decisions of the Courts of other States that a surgeon is not liable for the negligence of an associate when he has no management or control over him, nor is an anesthesiologist, when

called in, for special service, liable for independent acts of negligence on the part of a surgeon.

We find in 70 C. J. S. 978 that "a physician who merely administers an anesthetic to a patient operated on is not liable for the negligence of the operating surgeon, and the operating surgeon is not liable for the negligence of the physician administering the anesthetic in his absence where each doctor has been employed to perform his separate work independently of the other."

There is in law an expression "proximate cause." Who or what caused the injury. This includes a multitude of things. There being no joint control, no joint or concurrent act, or control over each other's acts, the anesthesiologist stands on his own and the surgeon on his.

Now back to our South Carolina cases.

In 1924, *Pittman vs. LeMaster*, 121 S. E. 677, 128 S. C. 98, a physician in Cherokee County brought action against a husband for attending his wife in child birth. He claimed the amount was \$150 based upon the theory of quantum meruit—that is, as much as he deserved.

There was no dispute between the parties as to the service rendered and it being satisfactory. The husband contended that he made a special contract covering the service, by which the physician was to be paid \$35.00 plus mileage of \$3.50, total \$38.50. Upon this issue the jury rendered a verdict for the physician for \$38.50.

An appeal was made involving the question of "burden of proof" where the plaintiff sues upon a quantum meruit and the defendant sets up a special contract.

The Supreme Court ordered a new trial, saying,

"Where plaintiff (physician) sues on a quantum meruit and proves the services and their value, he makes out a prima facie case upon the theory that an implied contract has been established to compensate him for their reasonable value."

and

"If the defendant (husband) relies upon a restrictive express contract fixing the amount of compensation, he must set it up as an affirmative defense, the burden of establishing which is upon him."

In another case, 134 S. E. 226, 136 S. C. 56, 48 ALR 243, we find an interior decorator bringing action against a physician for negligent treatment, alleging damages of \$10,000.

The lady was residing in Columbia and was engaged in the business of interior decorating. In November 1922 she consulted a prominent physician of that city about removing two warts from the index finger of her right hand. X-ray treatments were given, and her finger was severely burned. The jury rendered verdict for the defendant (the physician).

The lady appealed to the Supreme Court imputing error in trial, one of the grounds being as to the admission of testimony of two physicians "as to the efficiency and carefulness of the doctor and as to his reputation."

The Court held that the testimony was inadmissible on the issue of negligence, therefore, the case was reversed and sent back for a new trial. It said, "a physician might even be so skillful or competent in a general way, or might have an unexcelled reputation, and yet be guilty of the grossest negligence in his treatment of a particular case. x x x This view is supported by the weight of authority." The physician was charged with negligence and not with incompetency. The matter of fitness was not in issue. The Court also said,

"The use of dangerous instrumentalities such as electricity, radium, etc., in the treatment of a disease, demands not only skill and competency, but the exercise of such care as may be necessary and required by reason of the inherent danger of the instrumentality employed."

In *Smith vs. Baker*, 172 S. E. 767, 172 S. C. 75, our Court in 1934, in a short opinion, setting forth none of the testimony, held that in an action for malpractice in performing an operation and treatment that if there were any competent testimony presented in trial to support allegations of negligence, carelessness and recklessness on the part of a surgeon, it should be presented to a jury for determination.

The question of a parent being responsible for medical bills of an adult child arose in 1938 in the case of *Broadway vs. Jeffers*, 194 S. E. 642, 185 S. C. 523, 114 ALR 1244.

In 1935, late in the afternoon, at St. George, one Willie Jeffers, an adult, was seriously and

critically wounded by a deputy sheriff of Dorchester County. He was immediately rushed to the Summerville Infirmary for medical and surgical treatment. On examination it was found that a pistol ball had entered his chest, ranged downward, slit his intestines and buried itself in the pelvis. His father was notified of the condition and he arrived at the infirmary about 10 P. M., conferred with physicians, surgeons and nurses.

After some months, young Jeffers recovered, and two physicians, two nurses, all of whom had rendered services, and the infirmary presented bills to the father for payment, and he refused to pay them.

All entered suit against him, the cases being tried in Orangeburg County. The plaintiffs testified that the father had said to "spare no expense." He denies that he had incurred the expense. The trial judge submitted the cases to a jury on question as to whether or not the father had made a contract for payment of the bills. The jury returned verdicts for the plaintiffs, and the father appealed to the Supreme Court.

One of the questions presented on appeal was whether or not the father was responsible for the payment of the bills for his adult child.

The Court, in affirming the judgments of the jury said, "As a general rule, a request by a parent to a surgeon or physician to attend an adult child does not create an implied contract to pay for the services rendered by the physician or surgeon. However, this is not a rule of invariable application, for the conditions and circumstances surrounding the parties at the time the request is made, as well as the utterances on the subject, must be taken into consideration, and if, under the facts and circumstances, the physician or surgeon is justified in believing and relying on the parent's intention to pay for the services rendered, although there is no express promise to pay therefor, an implied contract is created, making the parent liable for the reasonable value of the services rendered. Of course, if there is nothing in the facts and circumstances suggesting to the physician or surgeon that

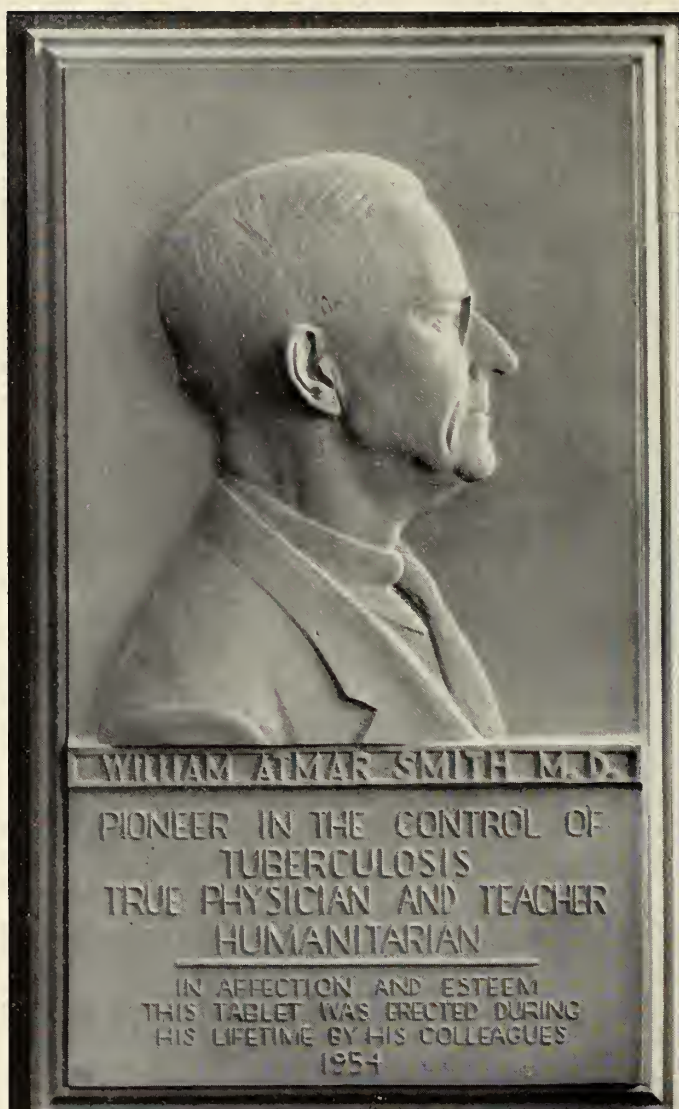
the parent intends to assume legal obligation to pay, at the time the request for services is made, the parent is no more legally liable for services rendered to his adult child, living away from his home than he would be for services requested to be rendered to a total stranger."

In *Wadsworth vs. McRae Drug Co.*, 28 S. E. 2d 417, 203 S. C. 543 (1943), our Court, discussing the liability of a pharmacist for placing a solution in one's eye as engaged in "practice of medicine," specifically held "that a corporation may not engage in the practice of medicine even through licensed employees."

The decision was based upon *Ezell vs. Ritholz*, 198 S. E. 419, 188 S. C. 39, in which it was held that an optometrist could not act in the practice of his vocation as an agent of a corporation. In that case (1938) the Court, with the late Honorable L. D. Lide, Acting Associate Justice, writing the opinion, aptly said, "The ethics of any profession is based upon personal or individual responsibility. One who practices a profession is responsible directly to his patient or client. Hence he cannot act in the practice of his vocation as an agent of a corporation or business partnership whose interests in the very nature of the case are commercial in character."

Now we know that all of the beautiful homes and office buildings which you anesthesiologists own are fully paid for and you have no mortgages on them. However, if you should hear of any one of your associates who may have to borrow money and secure a loan by a mortgage, you may tell him that under the cases of *Anderson vs. Purvis*, 44 S. E. 2d 611, 211 S. C. 255 (1947), and 67 S. E. 2d 280, 220 S. C. 259 (1953), if foreclosure proceedings are instituted against him that he will be entitled to offset the reasonable value of professional services rendered by him to the mortgagee and other members of his family, in the nature of quantum merit.

It has been a pleasure to be with you in such an enjoyable atmosphere and, after your hearing me, may we never meet under an anesthetic.



ADDRESS MADE AT THE PRESENTATION OF A PLAQUE OF DR. WILLIAM ATMAR SMITH

REMARKS BY DR. LEON BANOV

Before beginning our scientific session, we will proceed with the unveiling of a bronze plaque recently presented to Pinehaven Sanatorium by the professional colleagues of Dr. William Atmar Smith, as an enduring token of affection and esteem.

The Committee who had charge of this auspicious ceremony has requested me to make the presentation speech; and I don't mind admitting that for very personal reasons, I am proud to be the spokesman for this occasion, and consider it an honor and a privilege that I shall long remember.

This plaque is being presented tonight as a tangible token of the esteem, love and affection which his professional colleagues

bear towards him and is just another palpable testimonial to his warmth of character, his genial friendliness and his very able leadership.

Those of us who really know Billy Smith are not the least bit surprised that he has been recognized by his colleagues—our surprise perhaps is that he has not received such recognition before.

To give a complete history of Dr. Smith's medical career one would, at the same time, have to give a history of the progress of medicine in Charleston and in South Carolina during his lifetime, because he has had an active part in most of it.

I shall however, stress this evening his chief

medical interest,—his one true professional love—Pinehaven.

It seems but yesterday when after a great many years of wishing and hoping and talking and working on the part of a great many people including Dr. Smith, that a roughly constructed tuberculosis sanatorium was put together on the old Meeting Street Road, just a few miles north of the city limits, built out of old lumber and used equipment, the institution known as PINEHAVEN was dedicated to serve the public in the treatment and control of tuberculosis.

What that institution lacked in the way of facilities and equipment was more than made up by the enthusiasm displayed by its staff of workers; and for just about *thirty* years, Pinehaven has been rendering a service, comparable to many larger and wealthier institutions. The point I want to bring out is that usually a successful enterprise is found to be but the drawn out shadow of some outstanding personality who has consecrated the very best portion of his life in the building up of that institution; and in this, Pinehaven is no exception. The man that was most *responsible* for the medical success of Pinehaven—the man who through the alchemy of love, altruism and a zealous devotion to his duties, magically transformed a few rough walls and a roof into a real temple of healing, is the man that we are proud to be honoring this evening—Dr. Wm. Atmar Smith—a true physician—an able teacher—a real humanitarian, whose selfless devotion to his work and to his patients has brought him in very close touch with the heart-throbs of his followers, and it is not an accident or a coincidence that his patients in Pinehaven and elsewhere speak of him most affectionately as “Dr. Billy”.

Most physicians—certainly the older men—those who have been practicing for a long time—are looked upon with a certain amount of reverence—almost akin to awe—but in the case of “Dr. Billy Smith”, there is also to be found evidence of a deep love and an abiding affection for him on the part of his patients, that must itself prove of great therapeutic value to them.

In the beginning when Pinehaven first started, there were few tools with which to work. Fresh air—good food—rest—and an abiding faith in their institution, and in the physician who guided them back to health. As time went on, under Dr. Smith's leadership, Pinehaven adopted new methods of treatment one by one, as they were developed in various

portions of the world, and he surrounded himself with men who, fired with his own zeal and enthusiasm, likewise showed a devotion to their work beyond their call of duty. The same personal attributes that assured the success of Pinehaven, and the unusually fine service that he rendered there, also brought Dr. Smith national recognition. For instance, he has served during a number of years as Representative Director of the National Tuberculosis Association, and he served three terms on the Executive Committee of that great organization. He has served as Vice-President of the American Trudeau Society and later became a member of the Executive Committee of that Society. He also served as Vice-President and later as President of the Southern Sanatorium Association and as President of the Southern Tuberculosis Conference.

Locally, he has served on the Board of Directors of the South Carolina Tuberculosis Sanatorium and on the Board of Commissioners of the Roper Hospital, and he was Chairman of the Charleston City Board of Health for quite a number of years. He is the Regional Consultant on Tuberculosis for the Veterans Administration. His colorful career also included a Captaincy in the Medical Corp of the U. S. Army during World War I. For a number of years, he served as the faithful Secretary of the Medical Society of South Carolina and he later became its President. He also served as President of the South Carolina Medical Association. At present he is Clinical Professor of Medicine at the Medical College of South Carolina and a Consultant at the Roper Hospital. His outstanding achievement however, is the fine medical service that he has built up in Pinehaven during the past thirty years, in the capacity of Medical Director.

This bronze plaque should serve as an enduring reminder of the unselfish service that Dr. Smith has rendered to his community, to Pinehaven and to the cause of tuberculosis control. The work that he has accomplished for Pinehaven should of itself serve as an unforgettable memento—for the reason that only because of this work, has the institution continued to live and to grow—and to develop as it has done. Together, may they ever serve as an enduring reminder of the great work accomplished by Dr. William Atmar Smith, Medical Director of Pinehaven Sanatorium, in combatting tuberculosis, and may his genial kindly presence be with us for many, many more years to come.

CAT.



**PRESENTATION OF DR. WILLIAM WESTON'S PORTRAIT TO THE
MEDICAL COLLEGE OF SOUTH CAROLINA, FOUNDER'S DAY
NOVEMBER 4, 1954**

FRANK C. OWENS, M. D.

Place: Auditorium of the Medical College of South Carolina, Charleston.

Subject: Address being the presentation of a portrait by Charles Crowson of Dr. William Weston, to the Medical College of South Carolina by the medical colleagues of Dr. Weston.

The other day I read in the daily paper an article stating that the life expectancy of a baby born in 1900 was 49 years and one born today in 1954 was 72 years. This remarkable achievement is directly due to the work in prevention, diagnosis and treatment by the medical profession over that span of time. Every one of you doctors can proudly claim your share in adding those years to life. Perhaps, you individually added only a fraction of a second, but you did your part. Most of the added years were in the years of infancy and childhood. Those who dealt in pediatrics contributed a more substantial period of time to

the life span than did the rest of us.

Outstanding among that outstanding group is one we are here to honor today. Dr. William Weston, has given a life of service to the children—with result that more have lived, fewer have suffered and less have been maimed, and many an anxieties and heartaches of mothers and fathers have been prevented or alleviated. And, best of all, he is still doing it.

Dr. Weston was born in Richland County. He attended Richland County schools and the Patrick Military Academy of Anderson, South Carolina. Then to the University of South Carolina for two years, and then to Scwanee where he graduated. After that, he entered the Medical College of South Carolina where he graduated in 1896, just 58 years ago. He took post graduate medical work at Columbia Medical College and at Harvard. Dr. Weston did general practice until 1912, when he

specialized in pediatrics, being the second man in the South so to do. He is a leader and pioneer in the medical profession in that, he was one of the organizers of the American Academy of Pediatrics and the Southern Medical Association. He is past Counselor from South Carolina to the Southern Medical Association. He is past President of the Columbia Medical Society and was President of the South Carolina Medical Association in 1913. In 1936, he was chosen "Man of the Section" on Pediatrics in the American Medical Association.

For 20 years he served as delegate to the American Medical Association from the Pediatric section. His belief in the profession of medicine and his strict adherence to the high principles of the medical ethics and his understanding of the problems of medicine resulted in his opinion being sought by the rest of those shouldered with responsibility of shaping the policies of American medicine.

Dr. Weston shared his thoughts and knowledge with others, in that many medical meetings have benefited by his talks and papers. He was the first American physician to correctly describe aerodynia in 1922. His work on pellagra from 1909 to 1916 was outstanding. In 1928, he prepared a vitamin chart and 1916 organized the first Hook Worm Clinic in the world in Columbia, South Carolina. In 1930, he called attention to the prevalence of goiter in some states and the lack of it in South Carolina. He pointed out the large iodine content of our soil as an explanation. This gave added incentive to the growing of vegetables in South Carolina, and proved of marked benefit to our entire state. In connection with this new enthusiasm he aided in establishing the chair of Nutrition at the Medical College of South Carolina.

Always recognizing fully the necessity of adequate medical educational activities for the advancement of medicine, he exerted his not inconsiderable influence in securing appropriations for the Medical College. Throughout his medical career, and today, he is a staunch friend of our medical institution.

When we draw up specifications for an ideal representative of the medical profession; one who has the interest of his patient at heart; one who combines intelligent observation, a depth of knowledge, and a keen understanding; one who gives his time to the advancement of medicine yet finds time to take interest in the affairs about him; one who is sympathetic of the problems of his fellow prac-

tioners; one who is always the gentleman and physician, then we draw up the perfect description of Dr. William Weston, whose portrait I am proud to present to the Medical College of South Carolina as a gift from his admiring colleagues.

We will ask his attractive grand-daughter, Miss Ret Weston, the daughter of Dr. William Weston, Jr., to unveil the portrait.

PRESENTATION OF PORTRAIT

Dr. Kenneth M. Lynch—"Dr. and Mrs. Weston and family and friends of the Medical College of South Carolina: You have done us the favor of gathering with us in recognition of Dr. Weston. I say recognition rather than in honor of Dr. Weston because I feel that the honor in this case is done the Medical College.

In recognition of Dr. Weston as a distinguished and accomplished alumnus of this institution, I could attempt to emphasize the story which Dr. Owens has just presented to you, but out of consideration for Dr. Weston I shall not do that. However, what Dr. Owens has said, and what we shall say will be placed in the archives of this institution to accompany this splendid and magnificent gift to this school to which he has been so loyal; he has never failed, never at any time.

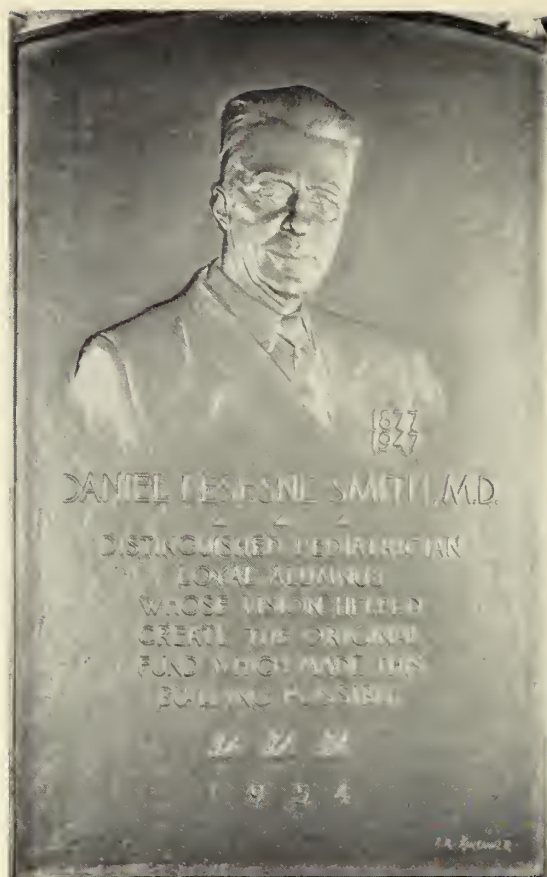
There is another particular reason why this portrait belongs here. Dr. Weston is a former member of the faculty of the Medical College of South Carolina. He is truly a servant of mankind.

It gives me great pleasure, it gives the institution pleasure to accept this gift from Dr. Weston's friends.

Now, may I embarrass Dr. Weston by asking if he would mind if I presented to you a living image of the portrait of Dr. William Weston." *Dr. Weston*: "Dr. Lynch, Dr. Owens and audience: May I say to you that this is the crowning occasion of my life. It has been a long one and until a few minutes ago I did not know it had been so distinguished, but I now feel reassured about that.

I am also very proud to know that this portrait will be in the Pediatric Section of our new building. I wish to say to this audience too, that the medical profession of South Carolina feels very proud of this institution. We feel that it has done a wonderful job in the past and that it has a wonderful future before it.

"Thank you for this occasion."



**PRESENTATION SPEECH AT UNVEILING OF A PLAQUE
COMMEMORATING DR. LESESNE SMITH
NOVEMBER 4, 1954 — MEDICAL COLLEGE OF SOUTH CAROLINA**

By GEORGE WILKINSON, M. D.

We are here today to unveil a plaque in memory of Daniel Lesesne Smith, a man who mastered the art of living. Born of noble parents, conditioned by the adversity of a cruel war and its aftermath of reconstruction, Dr. Smith, along with his brothers and sisters obtained an education. By sacrifice by his parents and by his own zeal, he finished college and studied medicine in Charleston. He began the practice of medicine in a mountain county, where practice was hard, both physically and emotionally. The appeal of a suffering and impoverished people—living far apart, with prejudices, rugged individualism and ignorance, especially in rudimentary hygiene—gave the young doctor the heat of the crucible necessary for building deep conviction. Traveling by foot and on horseback, over many long roads and trails, furnished the isolation necessary for thinking through many problems. Hovering over a kerosene lantern, with the lines around the whip, trusting a faithful horse, Dr. Smith often made his way home

far after the countryside lay asleep. His concern was not for his own convenience and pleasure, but for the patient left behind. Aside from the difficulty in diagnosis and the meager pharmacopeia at hand, his thoughts were about food, sanitation and bedside care.

With reluctance he moved to Great Falls, where conditions bettered his family. Density of population increased his patient roster. Less time was lost traveling lonely roads. But he worked long hours, and studied when many would have gone to bed. His education was advanced by attending medical meetings and availing himself of many short courses in medical centers.

In 1909 Dr. Smith moved his family to Spartanburg. By 1913 his work with children had increased to the point where he was obliged to confine his work to the field in which his deepest interest lay. During the summers he built up an enormous practice in Saluda, just across the line in North Carolina. His friends in Spartanburg joined hands and built

and maintained a baby hospital for the poor.

With the facilities created by himself, his family and friends, he still was not satisfied. From his own experience, he was convinced that in order to improve other physicians in the care of children, short courses in a cool, comfortable place—not too far from where the doctors lived—would provide a medium through which what he had learned could be made more widespread. So the Southern Pediatric Seminar was born. For the seminar Dr. Smith worked with great zeal and sacrifice. The faculty was made up of friends he had made while visiting and attending many hospital seminars and universities. Those who came to teach were delightfully entertained by his devoted wife, who took care of the faculty in her own home. In the first seminar only four students registered. Now the attendance has reached two hundred.

His second ambition was to see the Medical College in Charleston move forward and take its rightful place among other similar institutions. To this end he worked through the alumni, raising funds for a clinic building. As a member of the State Board of Health for many years, he endeavored to focus the activities of the board toward preventive medicine, particularly in children. Beginning in

1914, he attended the children at Cedar Springs. While president of the South Carolina Medical Association in 1925 and 1926, he was instrumental in starting a postgraduate seminar at the medical school in Charleston. In all of his activities, Dr. Smith had the happy faculty of putting himself in the background, while promoting those who occupied the stage, asking no credit and seeking none. His reward was satisfaction derived from implementing needed medical facilities.

Busy as he was, Dr. Smith took time out to master the art of living. He knew how to play and when to stop, how to make new friends and how to keep them. His principal activities were centered about his home, where his wife and four children absorbed his interest, shared in the fun, and grew up with him.

As host and hostess, Dr. and Mrs. Smith will always be loved by those who were privileged to visit in their home.

In the sunset of his career, he was sustained by the success of his children and the institutions to which he had contributed his life. All that is mortal of Dr. Lesesne Smith rests in the bosom of the soil in the red hill country close by the church that he loved, but his spirit pervades these halls and lives on in the shade of the tall trees on the hilltop at Saluda.



BENNETTSTVILLE MEETING

The Marlboro County Medical Society will hold its 33rd Annual New Year's Meeting on Thursday, January 13, 1955, at the Bennettsville Country Club. The social hour begins at 6 P. M., dinner at 7 P. M., and program at 8 P. M. The dinner will be served by the Junior Charity League, which has served all of these meetings, and will consist of turkey with all the trimmings, and the famous oyster pie.

Dr. H. R. Pratt-Thomas, Professor of Pathology at the Medical College of S. C., will give a talk on Carcinogenic Effect of Human Smegma and this will be discussed by Dr. J. R. Sosnowski of Charleston, Associate in Obstetrics and Gynecology.

All medical doctors in South and North Carolina are cordially invited to meet with us and enjoy the program and fellowship.

ATLANTIC CITY MEETING AMERICAN MEDICAL ASSOCIATION June 6-10, 1955

The Council on Scientific Assembly announces the deadline for those who wish to participate in the Atlantic City Meeting, either by reading a paper or presenting a scientific exhibit.

DEADLINE FOR SECTION PAPERS,
DECEMBER 15, 1954

DEADLINE FOR SCIENTIFIC EXHIBIT,
JANUARY 10, 1955

Applicants should communicate with the Secretary or the Representative to the Scientific Exhibit of the Section in which they are interested. Further information may be obtained from the Secretary, Council on Scientific Assembly, American Medical Association, 535 North Dearborn St., Chicago 10, Ill.

The Journal of the South Carolina Medical Association

EDITOR: Joseph I. Waring

82 Rutledge Ave., Charleston, S. C.

J. P. Cain ----- Mullins
J. D. Guess ----- Greenville
C. J. Milling ----- Columbia
H. R. Pratt-Thomas ----- Charleston

EDITORIAL BOARD
Vince Moseley ----- Charleston
Ben Miller ----- Columbia
W. H. Prioleau ----- Charleston
J. W. Jervey ----- Greenville

G. D. Johnson ----- Spartanburg
R. M. Pollitzer ----- Greenville
Hugh Smith ----- Greenville
Walter Mead ----- Florence

BUSINESS MANAGER: Mrs. C. G. Watson ----- 105 W. Cheves St., Florence, S. C.

Please send in promptly notice of change of address, giving both old and new; always state whether the change is temporary or permanent. Original manuscripts, subject to approval by the Editor and the Editorial Board, are desired for publication in the Journal. They should be typewritten, double spaced, on 8½ x 11 paper. References should be complete, and only such as relate directly to statements quoted in the paper. Illustrations will be used as funds permit, or as authors are willing to bear the necessary increase in cost. Short original articles are preferred to long reviews.

Office of Publication: (In care of the Editor) ----- Charleston, S. C.
Subscription Price ----- \$3.00 a Year

DECEMBER, 1954

The Georgia Medical Society Sesquicentennial

Not many years ago the Medical Society of South Carolina, the first enduring medical society of this state, and the sponsor of our present South Carolina Medical Association, celebrated its founding in 1789. The Society still exists, but since a few years ago is no longer a county unit of the state Association. Its name still creates confusion with the state organization.

On October 12-13 the Georgia Medical Society (of Savannah) celebrated 150 years of existence. It too, has become a county organization. It, too, is confused with the Medical Association of Georgia. And it, too, has a proud record of service and accomplishment which parallels that of the old Charleston society and promises new achievement in the future.

This Journal extends its congratulatory hand to its neighbor across the Savannah River.

Suggestions Regarding Medical College Expansion with Regard to The Roper Hospital and the Community

OVER-ALL OBJECTIVES:

I. Healthy development of the Medical College.

2. Preservation of the present high standard of medical service available to the community by maintaining Roper as a fully accredited hospital closely affiliated with the Medical College.

3. Retention for the Medical College of the good will and support of the community.

4. Encouragement of professional unity in general and in particular avoidance of a

schism between full time and part time faculty.

*PURPOSE OR OBJECTIVES OF THE EXPANSION PROGRAM: To raise standards of medical care in the state by

- Increasing the number of medical graduates, and personnel trained in cognate fields and ancillary services.
- Making available in the state certain skills and facilities commonly found only in the larger medical centers.
- Providing facilities for clinical and laboratory investigative work, an essential function of a teaching and post-graduate institution.
- Providing post-graduate courses.

HOSPITALS: The MEDICAL COLLEGE and THE ROPER.

The College Hospital.

- To supply clinical material for teaching and investigative work, particularly in the more or less specialty fields—in hospital pay and professional pay classes.

STAFF for COLLEGE HOSPITAL.

A. Hospital pay and agency cases.

- Full time faculty:—
 - Administrative.
 - Teaching and investigative work.
 - Patient care.
- Part time faculty:—
 - Teaching and investigative work.
 - Patient care.

*The following outline is based upon the premise that the Medical College authorities have decided to institute some form of group practice in the College clinics and hospital.

B. Professional Pay Patients.

1. Full time faculty.

According to Medical College practice ideology.

2. Part time faculty.

a) Limited number of cases based upon faculty rank, value of faculty member in teaching program, and nature of case as regards teaching and investigative value.

b) Patient care and professional fees governed by College practice and economic ideology.

c) patient care.

B. Professional pay cases.

1. Part time faculty as at present.

2. Full time faculty. (It is important that full time faculty maintains interest in pay department as well as in other departments of Roper)

a) Limited number of cases.

b) Professional fees governed by economic ideology of the College Hospital.

3. Non-faculty members of Roper Staff.

Roper Hospital.

To be closely affiliated with the Medical College but financially independent.

Objectives:—

1. To function as a community hospital of high standard.

2. To complement and supplement the clinical teaching facilities of the College Hospital

a) by providing cases and services such as acute, emergency and contagious, commonly found in a community hospital.

b) by providing cases on some of the specialty services.

Classes of patients (economic)

a) County indigent.

b) Agency cases over and above those desired by the College Hospital.

c) Professional pay patients.

STAFF FOR ROPER HOSPITAL.

A. County indigent and Agency cases.

1. Part time faculty.

a) administrative under heads of College teaching departments.

b) teaching and investigative work.

c) patient care.

2. Full time faculty.

a) administrative—as regards teaching and residency services.

b) teaching and investigative work.

SPHERES OF COLLEGE HOSPITAL AND ROPER.

The sphere of each must be reasonably clearly defined if the affiliation is to prove successful. The College Hospital will have state support; it is most important that Roper Hospital continue to have county support. The Roper Hospital must be recognized as the Community Hospital and accordingly the proper place for the care of the county indigent cases. It should have referred to it by the College Clinics such agency cases as are not needed by the College Hospital. Cases of the above types are of great value for teaching purposes and are essential for an intern and residency training program. Only by having such services can Roper Hospital be of real value in the teaching program and thus maintain a close affiliation with the Medical College. By such affiliation Roper Hospital would be able to retain its present status and continue to provide for the community the services of a scope and standard not commonly found in a community hospital. It would provide, for the part time faculty in particular, working conditions of a high standard; this is of importance as the part time faculty would have limited privileges in the College Hospital. Proper county support should enable Roper to provide facilities for colored physicians in the care of their patients. This is a most important consideration from a standpoint of community health. By this means adequate facilities could be obtained more economically than by building a separate hospital.

On the contrary, without a sizable block of indigent and agency cases, the Roper Hospital

would become essentially a private hospital doing such charity work as permitted by its endowment. It would become of limited value to the Medical College teaching program, it would have to curtail greatly its intern and residency services and accordingly lose its high standard of accreditation. Its value to the College would be practically lost, resulting in a separation of the two institutions. The community would suffer as the Roper Hospital would no longer be able to provide a reasonably complete medical service of a high standard. The part time faculty would be deprived of satisfactory working conditions. The College Hospital would not fill the breach as to the needs of the community except to the extent of taking a limited number of referred cases, and possibly the county indigent cases. The county would still be faced with the problem of providing suitable facilities for colored physicians in the care of their patients.

It is a paradox of modern medicine that within the shadow of the walls of some of the best hospitals a very poor grade of medicine is practiced. This is not necessary and should not be allowed to take place in Charleston. The best way to prevent such a happening is for the Medical College administrative authorities to recognize publicly that the Roper Hospital, as the community hospital, is the proper place for the care of the county indigent cases. Without such recognition the Roper Hospital is not in a firm position in dealing with the county authorities. In addition, due to its affiliation with the Medical College, the Roper Hospital should have referred to it a sizable block of agency cases. Only by earing for the county indigent and agency cases can the Roper Hospital continue to function on a high plane and be of greatest value to the community, as well as to the College in the student teaching program and in the training of interns and residents.

The Staff of the College Hospital and the Roper Hospital should consist of both full time and part time faculty members. It is desirable that both groups should have assignments in all departments of both hospitals. This would result in a close affiliation and a more effective teaching program.

FULL TIME FACULTY.

The full time system was originated by the Rockefeller Foundation through Dr. Welch at the Johns Hopkins Hospital. Its purpose was to permit those particularly qualified in teaching and research to be free of the cares and responsibilities of private practice as a source of income, by assuring them of an adequate salary. Since its beginning the system has undergone many modifications. In some cases it has been abused to the extent that the prestige of the full time position has been used primarily as the means of obtaining a large income from private patients; teaching and research have not always been given proper consideration. While abuses must be prevented, the purpose of the full time system would be defeated unless provision is made for adequate income for the full time faculty. Even though the nature of the full time position is such that the holder of it is dedicated to teaching and research at some sacrifice of financial gain, any method of remuneration should assure a reasonable income and contain an adequate but diminishing work incentive.

The prestige of a full time faculty position in the State Medical College is very great in the eyes of the physicians of the state, medical students, and particularly in the minds of the patients. It will be greatly increased by the new College Hospital which has been extensively publicized in the professional and lay press. It is reasonable to expect that the number of referred cases will be so great that there will be no problem as to remuneration of full time faculty members from this source. There may be some full time faculty members who do not wish to have their income earning power subject to the limitations of a full time position. These should enter the private practice of medicine and be on the part time faculty. There would be no objection to this in the transition period; however, in the future, measures should be taken to prevent the use of a full time faculty position as a means of subsidy and gaining recognition preparatory to entering private practice. A possible solution would be an agreement that full time faculty members would not enter private practice in the community for a stated number of years.

PART TIME FACULTY.

The Medical College should have on its part time faculty all physicians in the community who have professional and other qualifications of value to the teaching program on the undergraduate and graduate levels. In all departments they should be accorded privileges with corresponding responsibilities. The professional distinction between the full time and the part time faculty members should be no greater than that necessary for administrative purposes. Otherwise the part time faculty will tend to lose interest in the College and will be of relatively little value to it. The prestige of having a college connection is of distinct value to the part time faculty members, particularly so in the case of recently arrived physicians who come to Charleston to practice one of the specialties. The college connection would carry much less prestige, and in some cases be of doubtful value, if privileges in the College Hospital should be unduly restricted. It must be recognized that some of the present members of the part time faculty are well established professionally and have local and national recognition in their special fields. In some cases they would lend prestige to the College Hospital, an attribute of which it cannot have too much. The profession and the public would not readily understand part time faculty members with recognized professional qualifications and of demonstrated worth in the teaching program not being accorded reasonable privileges in a state institution.

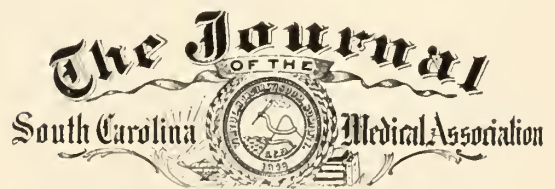
The major portion of teaching is still being carried by the part time faculty. It is through their support of the College that the full time positions are possible. As their livelihood is derived from the private practice of medicine they should not be placed at an undue disadvantage by a state institution. Private practice, with possibly a few exceptions, still offers the greatest opportunity for earning a large income, but this has been reduced greatly in the past 25 years due to increasing income taxes, increasing cost of office maintenance, much greater competition in the specialty fields, and the steady encroachment of State Medicine in various forms and guises. Private practice occupies an important place in the

scheme of medicine, both in providing medical services for a large segment of the population, and in serving as a yardstick for the establishment of standards of practice. It should not be handicapped by state institutions but should be assisted to continue on a high professional plane.

With the opening of the Medical College Hospital the Roper Hospital will be seriously affected professionally and financially. The professional problems which may arise should be satisfactorily solved by the planned close working affiliation with the Medical College. Financially, the loss of income from state controlled agency cases will present problems connected with operating the Main Building in which are housed both the agency and the county indigent patients. This will result in an increase in the cost of caring for the county indigent cases. The Roper Hospital is not tax supported, and in order to survive it must avoid operating at a financial loss.

In the near future decisions will have to be made concerning the operation of the Roper Hospital Main Building, the care of the county indigent cases, and provision for the colored physicians for the care of their patients. The solution to these problems will determine in large measure the value of the Roper Hospital to the community and to the Medical College, and the closely related standards of medical practice in Charleston. If the Roper Hospital is to function to the best interests of all concerned it must have the full backing of the Medical College.

Wm. H. Prioleau, M. D.



Forty Years Ago

DECEMBER 1914

The number was devoted to obstetrics. "Twilight Sleep" was under discussion. The first and fifth districts were organized. Dr. Sam Orr Black, a medical student, wrote a

paper on "Obstetrics in the Slums". The irritant effects of silver nitrate on the eyes of the newborn was noted. A paper read in Columbia on Renal Calculi had Dr. M. H. Wyman as one of its authors.

DEATHS

DR. BENJAMIN CLYDE BISHOP

Dr. Benjamin Clyde Bishop, Greenville, died October 5 after an illness of three weeks.

Dr. Bishop was born October 7, 1899, at Ehrhardt. He was educated at Carlisle Preparatory School at Bamberg, received his A.B. degree from Newberry College in 1920 and was graduated from the Medical College of South Carolina at Charleston in the class of 1926.

He served his internship at the Greenville General Hospital and for the past 27 years had been engaged in the practice of medicine in this city.

DR. ROBERT ELIJAH MASON

Dr. Robert Elijah Mason, 76, was born at Fair Play on June 8, 1878.

He was educated in the schools at Westminster, and completed his medical training at the University of Georgia where he was a honor graduate in the class of 1900.

He had spent the succeeding 54 years in the active practice of medicine at various points in South Carolina, and for a short time in Charlotte.

He started practice of medicine at Seneca, but later shifted to Charlotte, and then to McCormick County where he remained for 22 years, until 1927, when he moved to St. Stephens, in the lower part of the state.

He had practiced in Anderson for a decade or more.

DR. CLOUGH HENRY BLAKE

Dr. Clough Henry Blake, beloved physician and citizen of Greenwood, died October 16, 1954.

He attended school there and entered the Medical College of South Carolina in 1904, graduating in

pharmacy in 1906. He worked as prescription clerk in Lipscomb Drug Store in Columbia until 1908 when he returned to the Medical College and graduated with an M. D. in 1911.

Dr. Blake began his medical practice in Saluda with Dr. Sam M. Pitts. He married Miss Elma Pitts, daughter of Dr. and Mrs. Pitts in 1913.

They came to Greenwood in 1917. Dr. Blake took an active part in professional organizations. He was a member of the Greenwood, South Carolina and American Medical Associations. He was a member and several times president of the District Medical Society, composed of Greenwood, Abbeville, McCormick and Newberry Counties.

He served on the State Board of Medical Examiners from 1934 to 1952. He was a member of Phi Chi medical fraternity at college and a member of the Rotary Club of Greenwood.

DR. HUBERT CLAYTOR

Dr. Hubert Claytor, 91-year-old retired physician of Hopkins, died at his residence November 7.

A graduate of the University of Maryland, he came to Hopkins 68 years ago where he practiced medicine until his retirement ten years ago.

DR. JOHN B. COUSAR

Dr. Cousar was 49 years of age. Having decided on the practice of medicine as a profession he attended the University of Virginia Medical School. After completing his internship in a Chicago hospital Dr. Cousar became a medical officer with the Civilian Conservation Corps, being stationed near MacRae, Ga. After his tour of duty with the CCC he came back to Bishopville to practice medicine.

Dr. Cousar served with distinction with the Armed Forces during World War II, both in the United States and in Europe. Upon leaving the service he was promoted to the rank of full colonel in the U. S. Medical Corps. He received the Purple Heart and the Cross of Honor during his service in Europe.

Upon returning to Bishopville he reopened his office for the practice of medicine but had to retire from general practice some time later due to a heart condition. He became connected with the Veterans Administration office in Columbia, was transferred to the Florence office and then went back to Columbia where he was assistant chief medical officer with the Veterans Administration Hospital.



BLUE CROSS... BLUE SHIELD



An editorial on Blue Cross and Blue Shield in the October issue of *The Scribe* has occasioned considerable comment. Unless it be accepted as a frank and unfriendly attack on our South Carolina Plans—an attitude which is distasteful to me and one which I am unwilling to entertain—then it must have been written by one who is lacking in understanding of some basic principles of our operation.

The unfortunate incident which the author outlined was already familiar to me and one which our Executive Director had already taken steps to rectify. The clerk at Roper Hospital and the clerk contacted in the Charleston Blue Cross office both ruled in accordance with the provisions of the Blue Cross sub-

scription agreement. The provision in the agreement for emergency room coverage of accident and injury cases was made to cover only emergency cases and not to provide other out-patient hospital services. In order to restrict such services to emergency care of accident and injury, a time limit after the occurrence of the injury had to be fixed to define in part what cases were entitled to these benefits. A time limit of twelve hours is written into the agreement. It might just as well have been twenty-four hours, but it actually is only twelve hours. Had it been possible to have gotten a ruling in the particular case from someone with discretionary powers, the case would have been accepted for coverage. Un-

fortunately hospital clerks and even Blue Cross office clerks cannot be granted discretionary powers. They must abide by the provisions of the agreement. The clerks involved in this case did just that. When the circumstances were reported to the Executive Director, he immediately reversed their ruling and through the Medical Director took steps to correct what was not an error in fact but which was inequitable. That he was willing and able to do this illustrates one important difference in attitude toward the subscriber by Blue Cross and that of many commercial insurance carriers toward their policy holders. Considerations of equity are placed ahead of strict conformity to provisions of the contract.

Knowledge and understanding spread slowly. Understanding of provisions and of restrictions of insurance contracts is rarely secured by a simple reading of the contracts. Policy holders usually have to be taught and taught as individuals and not by methods of mass education. When the insured learns by such teaching that his then present need is not covered by his contract, his mental attitude naturally is not good, and sometimes it is truly ugly. It takes tact and sympathetic understanding by him who has to do the teaching. However, these disappointing situations give a marvelous opportunity to hospital employees and to doctors to do a real service to the patient, to the hospital and to the Plan. Although it is true that the hospital frequently has to take the brunt of the patient's anger, and by hospital is meant usually some lesser employee, it is also true that the doctor frequently gets his share of it as well. In either instance, Blue Cross (or the commercial carrier) is hurt most. The interests of the hospital and those of the doctor are intimately tied up with prepaid hospital insurance. Because of those interests, there is selfish motive in assisting in the education of the Blue Cross member as to what his rights and privileges are under his contract. It is their further opportunity, by constructive criticism, to attempt to correct inequities in the agreement. However, there is an important difference between inequities and extent of coverage. The one applies to the administration of the benefits provided in the contract. The other applies to the incorporation in the contract of new coverages. The latter involves a consideration of benefits in relationship to costs. Blue Cross can give only those benefits within the limits of its income from membership dues.

The editorial referred to made reference to allowances paid to doctors by Blue Shield and implied that nearly every group of doctors was dissatisfied with the allowances except the orthopedic men and the obstetricians. It has

been our experience that the obstetricians have been the most dissatisfied and the least cooperative of any group. This has come about because of the fact that Blue Shield so far has been unable to include coverage for prenatal and postnatal care, which obstetricians rather generally include in an overall fee, and because the fee allowance for complicated deliveries, so frequently accomplished by the original doctor and a consultant, is admittedly inadequate.

Many orthopedic specialists and surgeons handling complicated fractures and other long drawn out orthopedic conditions have not been happy over the fee allowances.

Our Plan began as a surgical and obstetrical plan, with service benefits to low income members. The basic idea in setting up a fee schedule was to set a fee which was approximately two-thirds of the average normal fee charged by our doctors for the service under question, when rendered to low and middle income people. Participating physicians pledged themselves to accept the fee set as full payment of services rendered such people. Although fees for specific services are still occasionally altered to remove inequities, there seems to be rather general satisfaction with the schedule now in effect. The chief gripe, if it is a gripe, is the maximum limit of \$150.00 for any one operation, regardless of its technical difficulties, and a maximum combined fee of \$200.00 for the surgical service of any single disability.

Medical (non-surgical) coverage was added about two years ago, tentatively and more or less experimentally. Service benefits were not provided for medical illnesses. Neither were non-hospitalized cases covered. There was a very small additional charge made by the Plan for this admittedly inadequate medical coverage. Partial anesthetic coverage for surgical and obstetric procedures was included in medical coverage. The new contract specifically excluded both medical and surgical benefits during a single hospital admission. No provision for consultation fees was provided. No service benefits were included.

The reception of the new medical coverage by the doctors seems to have been good. Generally, they seem to be jealous of their rights to the fees provided. There have been suggestive indications that the medical allowances of the Plan may at times be more than normal charges. There are some suggestive signs that encourage us to believe that medical service benefits may soon be incorporated in the agreement.

My colleagues, these Plans are your plans. The respective boards are attempting to operate them for you and your patients. Both

Plans are having difficulties. These difficulties stem first from what is termed over-utilization (more than a normal expected number of claims per unit of membership—claims for unnecessary hospitalization, unnecessarily long hospitalization, unnecessarily frequent use of x-ray, laboratory and other examinations and unnecessarily expensive drugs, and unnecessary surgery or surgery which could safely be postponed until after the termination of a waiting period.) They stem secondly from a sincere effort to furnish every bit of coverage that can be given for the subscription income received. Your continued cooperation and patience is earnestly requested.

J. Decherd Guess

NEWS

Florence Doctors H. J. Stokes and L. D. Lide delivered a paper, "Practical Points in Ophthalmology," before a meeting of some 200 eye, ear, nose and throat specialists from the two Carolinas in Durham, N. C., Nov. 3 through 6.

Dr. E. B. Michaux and family have been in Miami, where he officiated as President of the Seaboard of Surgeons.

Dr. Sam Cantey of Marion was elected President of the Pee Dee Medical Association at the Annual Meeting held in Florence. Other Officers elected were:

Charles Kingsbury, Secretary; Wally Hart, Treasurer. Vice Presidents: Jim Thraillkill, Chesterfield; Marshall Coleman, Darlington; Rufus Cain, Dillon; Gene Guyton, Florence; Wayne Reeser, Horry; Roy Howell, Marlboro; and Sam Witherspoon, Marion.

In a special ceremony the doctors of the Pee Dee in practice for 40 years were recognized, and honored with a suitable certificate from the Association.

DOCTORS NAMED to receive appreciation awards and the year they began practice is as follows:

O. A. Alexander, Darlington, 1914; W. J. Beasley, Hartsville, 1904; William L. Beyerly, Hartsville, 1911; John R. Claussen, Florence, 1913; E. Marvin Dibble, Marion, 1900; E. B. Gamble, Olanta, 1911; and Benjamin F. Hardy, Dillon, 1913.

Also, James P. Harrison, Cheraw, 1913; T. H. Honck, Florence, 1912; Frank L. Martin, Mullins, 1912; Robert M. Newsom, Ruby, 1911; Joseph L. Powe, Hartsville, 1904; Frank K. Rhodes, Florence, 1911; Chandler M. Scott, Hartsville, 1913; D. D. Strauss, Bennettsville, 1912; Maurice L. Townsend, Society Hill, 1906; and Eugene M. Williams, Lake City, 1910.

Dr. Carl A. Green, discharged from the U. S. Air Force October 12, has begun the practice of medicine, specializing in eye, ear, nose and throat conditions, at Taylor and Harden Streets, Columbia.

Dr. Green is a graduate of Meharry Medical College.

He is a diplomate of the American Board of Ophthalmology and a member of the American Academy of Otolaryngology and Ophthalmology.

While in the service Dr. Green was chief of ophthalmology at Sampson Air Force Base Hospital, Geneva, N. Y.

Ruth T. Sanders, M. D. has announced the opening of an office for the practice of roentgenology at Catawba Street, Spartanburg, South Carolina.

SOUTH CAROLINA'S STATUTES CONCERNING NATUROPATHY

56-901. *Naturopathy defined.*

"Naturopathy" is hereby defined to mean the use and practice of psychological, mechanical and material health sciences to aid in purifying, cleaning and normalizing human tissues for preservation or restoration of health according to the fundamental principles of anatomy, physiology and applied psychology, as may be required. Naturopathic practice employs, among other agencies, heat, light, water, electricity, psychology, diet, massage and other manipulative methods. These agencies are known as psychotherapy, suggestotherapy, hydrotherapy, electrotherapy, mechanotherapy, biochemistry, external appliances, mechanical and electrical appliances, hygiene, first aid, sanitation, heliotherapy and dietetics. The use and practice of phytotherapy, minor surgery, obstetrics and gynecology, autotherapy and biologicals shall be a part of and included in the practice of naturopathy.

-902. *Board of Examiners.*

There is hereby created a board of naturopathic examiners to be known as the South Carolina Board of Naturopathic Examiners. Whenever the terms of office of the members of the Board are about to expire the South Carolina Naturopathic Association shall recommend to the Governor, who shall appoint, four members of the Board, who shall be members of the South Carolina Naturopathic Association and whose term of office shall be for a period of four years.

-903. *Organization; rules and regulations; meetings.*

The Board shall meet within ten days after its appointment every four years and organize by electing a president, secretary and treasurer and adopting reasonable rules and regulations for the transaction of business. It shall meet in June and November of each year.

-904. *General power with respect to naturopathy.*

The Board may transact any business or legal matters pertaining to the practice of naturopathy in this State.

-905. *Application and fee.*

All applicants for examination and licensing must file with the secretary of the Board at least fifteen days prior to its regular meeting time proper credentials and a fee of twenty-five dollars.

-506. *Qualifications of applicants.*

Each applicant for examination and licensing to practice naturopathy in this State must be a graduate of a regular four year high school course and a two years premedical course and must have completed and hold a diploma from an accredited school, college or university of naturopathy conferring the degree of doctor of naturopathy recognized by the South Carolina Board of Naturopathic Examiners.

-507. *Recognized school, college or university of naturopathy defined.*

Any Class A school, college or university legally chartered and having a regular professional course in naturopathy and its allied branches of four years of nine months each, making a total of four thousand four hundred hours and including in its curriculum bacteriol-

ogy, anatomy, diagnosis, comparative medicine, physiology, etiology, hydrotherapy, histology pathology, phytotherapy, biology, toxicology, electrotherapy, chemistry, hygiene and sanitation, massotherapy, analysis, biochemistry, orthopedics, symptomatology, physiotherapy, practice of naturopathy, autotherapy, ethics and jurisprudence, dietetics, gynecology and obstetrics shall be recognized by the South Carolina Board of Naturopathic Examiners and shall be a recognized school, college or university of naturopathy.

-908. *Subjects and type of examinations.*

The Board may name the branches of naturopathy and its allied sciences in which the applicant for licensing shall be examined and shall hold written or oral examinations or both, in the discretion of the Board.

-909. *Reexamination after failure.*

In case an applicant fails to pass the examination he shall be entitled to a second examination at the next regular meeting of the Board.

-910. *Licensing of nonresident naturopaths.*

Any person of good moral character licensed by a naturopathic board of any other state whose requirements are commensurate with the requirements of this State may in the discretion of the Board and upon the payment of fifty dollars be granted a license to practice in this State without examination.

-911. *Licensees register in clerk's office.*

Every licensed naturopathic physician shall be required, after receiving a certificate of qualification or license from the Board, to register in the county in which he resides with the clerk of court's office and pay a fee of fifty cents.

-912. *Authority and duties of naturopaths.*

All naturopathic physicians who are in active practice and licensed in this State may sign birth, death and health certificates, shall be required to report all infectious and contagious diseases to the State Board of Health and shall be accorded the use of the State biological and chemical laboratories.

-913. *Naturopaths not to practice medicine, osteopathy, etc.*

Nothing in this chapter shall be held or construed to authorize any naturopathic physician licensed hereunder to practice materia medica or surgery, nor shall the provisions of this chapter in any manner apply to or affect the practices of osteopathy, chiropractic, Christian Science or any other treatment authorized or provided for by law for the cure and prevention of diseases and ailments.

-914. *Grounds for suspension or revocation of license.*

The Board may suspend or revoke, by a majority vote of its total membership, any license which may have been given under the provisions of this chapter to any practitioner to practice naturopathy in this State for any one or more of the following causes shown at a hearing before it, to wit:

(1) That any diploma, license, certificate or other credential illegally or fraudulently obtained by the applicant was presented to or filed with the Board and considered by it in granting the license;

(2) That a license has been applied for and issued under an assumed name for the purpose of shielding dishonesty or a criminal record;

(3) Conviction of any criminal operation or habitual drunkenness or adjudication of insanity;

(4) Immoral or dishonorable conduct which would reflect upon the licensee's professional competency;

(5) Addiction to any harmful drug habit;

(6) Unprofessional conduct bringing discredit upon the profession; and

(7) Conviction of a felony or misdemeanor involving moral turpitude or professional dishonor in which case the record of the conviction, or a certified copy thereof, certified by the clerk of court and by the judge in whose court the conviction is had shall be conclusive evidence thereof.

-915. *Charges against licensee and notice thereof.*

Whenever the Board shall have cause to believe that any license issued by it should be revoked because of the existence of some ground for revocation as set forth in 56-914, it shall file or cause to be filed with its secretary written charges against the accused, specifically setting forth the offense, act or conduct complained of. A copy of such charges shall be forthwith delivered to the accused practitioner in person or by registered mail or left with some person of sound discretion either at his place of business or place of last known residence, either of which shall constitute sufficient notice to justify proceeding with a hearing of the charge. In addition to the delivery of a copy of the charges, the Board shall, at the same time, advise the accused of the hour, day and place of a hearing of the charges and warn him to be present, if he so desired, and to defend the action.

-916. *Hearing and finding of Board.*

The accused practitioner shall be permitted to be present in person and by attorney at the hearing and at the taking of all testimony relative to the charges. Any member of the Board may administer oaths to all persons testifying at any such hearing. The accused shall be allowed at least ten days from the date of such notice to him of the charges before the hearing shall be held. The Board shall receive reasonable evidence, whether for or against the accused, and the Board shall not be bound by the strict rules of evidence as required in a court. The findings of facts of the Board shall be conclusive. The Board shall reach its findings and set forth its action thereon and a certified copy of such findings and of the action of the Board shall be served upon the accused practitioner.

-917. *Appeal.*

The practitioner, if he is dissatisfied, may apply to the court of common pleas of the county in which he resides or practices for a writ of certiorari and the questions to be determined by the court on such writ of certiorari shall be as provided by law and the decisions of the Supreme Court of this State.

-918. *Pay certain funds to public school fund.*

If at the close of any fiscal year there remains in the hands of the Board more than five hundred dollars over and above all indebtedness, the amount so held shall be turned over to the public school fund.

-919. *Penalties.*

Any person violating any of the provisions of this chapter shall be guilty of a misdemeanor and punishable in the discretion of the court.

PRESIDENT'S PAGE

The increasing number of suits at law against physicians is a problem of concern to all of us. If the present trend continues, it may become necessary for the component State Medical Associations to attempt to underwrite their own mal-practice insurance. Our best thoughts should be concentrated on how to combat this sinister threat to medicine.

It appears to the writer that the application of the golden rule in daily dealings with our patients will do more than anything to remedy the situation. If the feeling can be brought about in each individual patient that the physician's utmost is being done in his behalf, then it is very doubtful if a suit would be entered. It stands to reason that if there were a cordial relationship between the physician and the patient, the patient would endure much before bringing suit against one in whom he has confidence and trust. Of course, there is a certain percentage of individuals who lack the basic qualities and virtues but they should be recognized and handled with extreme caution.

A better physician-patient relationship would decrease the number of mal-practice suits and at the same time lessen the likelihood of State Medicine.

Tom Gaines

Amebiasis¹ a "Poorly Reported" Disease

*Until serious complications arise,
amebiasis may pass unrecognized and
patients receive only symptomatic treatment.*

Although amebiasis is a disease with serious morbidity and mortality, statistics on its incidence¹ are incomplete because its manifestations are not commonly recognized and consequently not reported.

"Vague symptoms² referable to the gastrointestinal tract, such as indigestion or indefinite abdominal pains, with or without abnormally formed stools, may result from intestinal amebiasis. Not infrequently in cases in which such symptoms are ascribed to psychoneurosis after extensive x-ray studies have been carried out, complete relief is obtained with antiamebic therapy."

To prevent possible development of an incapacitating or even fatal illness and to eliminate a reservoir of infection in the community, diagnosing and treating³ even seemingly healthy "carriers" and those having mild symptoms of amebiasis is advised.

Early diagnosis¹ is important because infection can be rapidly and completely cleared, with the proper choice of drugs and due consideration for the principles of therapy. For treatment of the bowel phase these authors find Diodoquin "most satisfactory."

For chronic amebic infections, Goodwin⁴ finds Diodoquin to be one of the best drugs at present available.

Diodoquin, which does not inconvenience the patient or interfere with his normal activities, may be used in the treatment of acute or latent forms of amebiasis. If extraintestinal lesions require the use of emetine, Diodoquin may be administered concurrently. It is a well tolerated and relatively nontoxic orally administered amebicide, containing 63.9 per cent of iodine.

Diodoquin (diiodohydroxyquinoline), available in 10-grain (650 mg.) tablets, reduces the course of treatment to twenty days (three tablets daily). Treatment may be repeated or prolonged without



Endamoeba histolytica (trophozoite).

serious toxic effect. It is accepted by the Council on Pharmacy and Chemistry of the American Medical Association. G. D. Searle & Co., Research in the Service of Medicine.

1. Hamilton, H. E., and Zavala, D. C.: Amebiasis in Iowa: Diagnosis and Treatment, J. Iowa M. Soc. 42:1 (Jan.) 1952.

2. Goldman, M. J.: Less Commonly Recognized Clinical Features of Amebiasis, California Med. 76:266 (April) 1952.

3. Weingarten, M., and Herzig, W. F.: The Clinical Manifestations of Chronic Amebiasis, Rev. Gastroenterol. 20:667 (Sept.) 1953.

4. Goodwin, I. G.: Review Article: The Chemotherapy of Tropical Disease: Part I. Protozoal Infections, J. Pharm. & Pharmacol. 4:153 (March) 1952.

OPINION OF JUDGE HENDERSON ON NATUROPATH'S SUIT

STATE OF SOUTH CAROLINA } IN THE COURT OF
COUNTY OF SPARTANBURG } COMMON PLEAS

Dr. M. S. Dantzler, individually and as President of the South Carolina Naturopathic Physicians Association, and Dr. J. B. Branyon, individually and as Secretary-Treasurer of the South Carolina Naturopathic Physicians Association, }
Plaintiffs, } ORDER
—vs— }
T. C. Callison, Attorney General of the State of South Carolina, }
Defendant. }

This is a class action on behalf of all duly licensed Naturopathic Physicians. The Complaint in effect states that due to previous opinions of the Attorney General of South Carolina Naturopathic Physicians are not allowed to sell or use narcotic drugs, or at least are embarrassed in obtaining and handling such drugs.

By the Demurrer the defendant admits the status of the plaintiffs and their right to sue, and puts the question squarely before the Court as to whether or not licensed Naturopathic Physicians are given the right to administer medicine and drugs, including opium and its derivatives such as morphine, codeine and the other drugs listed in the Complaint. While admitting duly pleaded statements of fact, the Demurrer admits no conclusion of fact or law.

Naturopathy is defined by Section 56-901 of the 1952 Code of Laws of South Carolina as follows:

"*Naturopathy*" is hereby defined to mean the use and practice of psychological, mechanical and material health sciences to aid in purifying, cleaning and normalizing human tissues for preservation or restoration of health according to the fundamental principles of anatomy, physiology and applied psychology, as may be required. Naturopathic practice employs, among other agencies, heat, light, water electricity, psychology, diet, massage, and other manipulative methods. These agencies are known as psychotherapy, suggesto-therapy, hydrotherapy, electrotherapy, mechanotherapy, biochemistry, external appliances, mechanical and electrical appliances, hygiene, first aid, sanitation, heliotherapy and dietetics. The use and practice of phytotherapy, minor surgery, obstetrics and gynecology, autotherapy and biologicals shall be a part of and included in the practice of naturopathy."

In 1949, the Legislature adopted what is now Section 56-907 showing the course of study which Naturopaths are required to take. This is as follows:

"Any Class A school, college or university legally chartered and having a regular professional course in naturopathy and its allied branches of four years of nine months each, making a total of four thousand, four hundred hours, and including in its curriculum bacteriology, anatomy, diagnosis, comparative medicine, physiology, etiology, hydrotherapy, histology, pathology, phytotherapy, biology, toxicology, electrotherapy, chemistry, hygiene and sanitation, massotherapy, analysis, biochemistry, orthopedics, symptomatology, physiotherapy, practice of naturopathy, autotherapy, ethics and jurisprudence, dietetics, gynecology and obstetrics shall be recognized by the South Carolina

Board of Naturopathic Examiners and shall be a recognized school, college or university of naturopathy."

There is a section of the Code, Section 56-910, which allows those who have been licensed by other States to practice naturopathy within this State upon the payment of Fifty (\$50.00) Dollars. Section 56-912 gives the right to Naturopathic Physicians to sign birth, death and health certificates. However, of great significance is Section 56-913, which is as follows:

"Nothing in this chapter shall be held or construed to authorize any naturopathic physician licensed hereunder to practice materia medica or surgery, nor shall the provisions of this chapter in any manner apply to or affect the practices of osteopathy, chiropractic, Christian Science or any other treatment authorized or provided for by law for the cure and prevention of diseases and ailments."

There have been many cases from other States defining naturopathy. This definition is found in 70 CJS pages 808, 809:

"A system of physical culture and drugless treatment of disease by methods supposed to simulate or assist nature; a drugless system of therapy by the use of physical forces, such as air, light, water, heat, massage, etc.; a process or system whereby remedies for disease are discovered and whereby they are applied to the healing of disease. It is one of a number of fields in the art of healing which have been recognized by some legislatures as accepted processes of preventive and curative medicine. Naturopathy embraces, under some statutes, the use and practice of psychological, mechanical, and material health sciences to aid in purifying, cleaning, and normalizing human tissues for preservation or restoration of health according to the fundamental principles of anatomy, physiology, and applied psychology. The practice of naturopathy, under some statutes, includes the use and practice of phytotherapy, and also minor surgery, obstetrics and gynecology, autotherapy, and biologicals."

Licenses to Naturopaths are provided for by the Code sections above set out. However, they are limited licenses, and not general licenses to practice all branches of medicine. See 70 CJS page 868, from which the following is taken:

"Licenses issued under some statutes are limited with respect to the scope of practice permitted, since persons pretending knowledge and instructions in a pursuit of a particular method and holders of restricted licenses may not practice branches of the art of healing not embraced within the subjects on which the licensee has been examined, and which by his certificate he is authorized to practice."

This limitation is recognized by the ease of *Williams v. Capital Life and Health Insurance Company*, 209 SC 512, 41 SE 2d 208. Incidentally, this case goes into the history of the naturopaths in this State to some extent. It is the first ease on Naturopathy in this jurisdiction. It throws considerable light upon the history of the Acts involved. The only other ease is that of *Jacoby v. State Board of Naturopathic Examiners*, 219 SC 66, 64 2d 138. This goes into the powers of the Board of Naturopathic Examiners. Neither case, however, decides the question at issue here.

It will be noted that Code Section 56-901 lists many methods of treatment open to Naturopaths. Most of these are treatment by heat, light, water, electricity, psychology, diet, massage and physical manipulations. In that section there is a total absence of anything allowing Naturopaths to practice materia medica.

Actually Section 56-913 says that nothing in the chapter shall be held or construed to authorize any naturopath to practice materia medica or surgery. Section 56-907 does not even provide that prospective naturopaths study materia medica. There are many definitions for materia medica found in WORDS AND PHRASES. The following are some of the definitions of these terms:

"Materia Medica: 'Drug remedies are known collectively as the Materia Medica or medicinal materials. It is a science that deals with the study of sources, constituents, physical properties, chemical characteristics, preparations and dosage of medicinal materials.'

Davison Textbook on Pharmacology—1949.
"Materia Medica: 'The study of drugs from the standpoint of their botanical and chemical properties.'

Grollman's Textbook on Pharmacology—1954.
"Materia Medica: 'Drug remedies are known collectively as the 'Materia Medica' or medicinal materials. The science which deals with the properties of drugs is called Materia Medica.'

Bastedo's Textbook of Pharmacology—1947.
"Materia Medica is the division of Pharmacology that treats of the sources, descriptions, and preparation of drugs. It is an older term and its use in medicine appears to be diminishing. Years ago as a didactic, descriptive body of knowledge concerning drugs, materia medica had a prominent place in the medical curriculum. It has now been replaced by the experimental science of pharmacology."

Krantz and Carrs Textbook of Pharmacology—1954.

It is argued that by allowing the practice of phytotherapy the Legislature meant to allow the use of drugs by the plaintiffs. The word "phytotherapy" is defined in 70 CJS at page 815 as:

"The use of plants to heal; treatment by means or with the aid of plants or remedies of botanical origin."

This word has been construed by the United States Circuit Court of Appeals in the case of *Perry v. Larson*, 104 F 2d 728, as not including the use of narcotic drugs or opium derivatives. Incidentally, the Perry case involved an attempt by the Naturopaths of Florida to use and prescribe narcotics under the law then existing in Florida. The case is first reported in 25 F Sup 728 and affirmed by the Circuit Court of Appeals in 104 F 2d 728. After this decision, which was in 1939, the Florida Legislature amended the Florida law and a lower court's opinion held that the Naturopaths could use these drugs under the amended Act. This year the Florida Court again had the opportunity to study the naturopathy situation as will be seen by reference to the case of *State Department of Public Welfare v. Melser*, 69 So. 2d 347, about which more later.

It is contended that the use of the word "biologicals" in Section 56-901 gives the plaintiffs the right to use drugs. I do not think this is so. The word "biologicals" is defined as follows:

"Biologicals—Medicinal preparations made from micro-organisms and their products: they include serums, vaccines, antigens and anti-toxins."

The American Illustrated Medical Dictionary—Dorland 21st Edition.

It is also suggested that by authorizing the plaintiffs to practice minor surgery, obstetrics and gynecology, they were given the right to use the drugs desired by them. This question was up in the case of *Georgia Association of Osteopathic Physicians & Surgeons, Inc. v. Allen, Collector of Internal Revenue*, reported first in 31 F Sup 206, and affirmed in 112 F 2d 52. It ap-

pears from these cases that the State of Georgia in 1935 enacted a statute forbidding the sale of narcotics except on written order or prescription of a lawfully authorized practitioner of medicine, dentistry, or veterinary medicine. The statute further allowed physicians, dentists and veterinarians to prescribe, administer and dispense narcotic drugs. It was claimed that the Osteopaths were physicians within the meaning of the 1935 law and that they had the right to use the drugs as an integral and essential part of their professional work.

From 112 F 2d 52, it will appear that Osteopathy from the beginning contemplated a drugless science of medicine and that Osteopathy is the very antithesis of any science of medicine involving the use of drugs. The same applies to the practice of Naturopathy, as will be seen from its definition in *Corpus Juris Secundum*, *American Jurisprudence*, and *Words and Phrases*. However, the Osteopaths claimed that since they were given the right to practice obstetrics, they impliedly were authorized to use narcotics. The Court in 31 F Sup 205-206 held that this did not allow the use of drugs but only allowed the practice of obstetrics according to the school of the Osteopaths, and that since Osteopathy is a drugless system of medicine, no drugs could be used in practicing obstetrics, especially in view of the flat prohibition of the use of narcotics except by licensed surgeons, dentists and others allowed by law to use these drugs.

It is significant that in the rules and regulations of the State Board of Health governing the practice of midwifery in this State, the midwives are forbidden to use any drugs except under the immediate instructions of a licensed physician, showing that obstetrics can be performed without drugs.

We now come back to the Florida case of *State Department of Public Welfare v. Melser*, *supra*. By examination of the report of this case and of the case of *In Re: Complaint of Melser*, 160 Fla. 333, 32 So. 2d 742, it will be seen that the Complaint in this case is practically word for word, or in many respects, the same as the Complaint in the last Florida case. The significant thing is, however, that after the United States Circuit Court of Appeals in the *Perry v. Larson* case, *supra*, has held that Naturopaths could not prescribe narcotics, the Florida Legislature amended the law, and that thereafter the Florida Court upheld the right of the Naturopaths in this respect. When the last Melser case came up, it was decided by the Supreme Court of Florida en banc, which adhered to the principle of stare decisis and upheld its opinion reported in 32 So. 2d 742, which was nothing but an affirmation of the lower Court's opinion without any reasons or written opinion. To fully understand the last Melser case, it should be read in toto. There were strong dissents in this case. The first opinion filed held that Naturopaths could not use these narcotic drugs. A rehearing was granted; and on re-hearing it was held that the question of whether or not these drugs could be used was not properly before the Court and that, therefore, it would stand on its opinion reported in 32 So 2d 742. The final opinion was a four to three one. The Court, in its 1953 opinion, quotes from the *Perry v. Larson* case above set out as follows:

"In a well reasoned opinion in the case of *Perry v. Larson*, 5 Cir., 104 F 2d 728, 730, which construed the Florida 'Uniform Narcotic Drug Law', it was held that a naturopath was not authorized to prescribe narcotic drugs. In that opinion Judge Sibley, speaking for the United States Court of Appeals for the Fifth Circuit, said:

"But it is argued that the statute expressly allows phytotherapy, which means the use of plants to heal, and that these narcotics are derived from poppy plants and cola leaves. But so are

aconite and belladonna, also powerful drugs, derived from plants. Although such drugs are of plant origin, their prescription is not the phytotherapy meant, but it is the use of materia medica reserved to the practitioner of medicine and denied to the naturopathic practitioner. The medical terms used in the statute in describing naturopathy are strange to common speech, and the proviso which follows and limits them must be given controlling effect. The office of a proviso, generally, is either to except something from the enacting clause, or to qualify or restrain its generality, or to exclude some possible ground of misinterpretation of it, as extending to cases not intended by the legislature to be brought within its purview."

Section 56-1101 of our Code defines Osteopathy in part. This definition reads in part as follows:

"Osteopathy is hereby defined as a complete system of therapeutics embracing all scientific subjects pertaining to the healing art except materia medica.—The practice of osteopathy consists principally in the correction of all structural derangements by manipulative measures, including physiotherapy and electrotherapy, minor surgery, diet, hygiene and obstetrics.

The Georgia law is practically the same, and it was held in the case of *Georgia Association of Osteopathic Physicians & Surgeons, Inc. v. Allen, Collector of Internal Revenue*, 112 F 2d 52, that such statutory provisions do not allow osteopaths to use narcotic drugs. The Osteopathy law ties in with our Naturopathy law. Both laws omit from the practice of such healers the use of materia medica.

Our Uniform Narcotic Drug Act was passed in 1934, at which time we had no laws allowing the practice of Naturopathy. The word "physician" is defined in Section 32-1462(1) as follows:

"'Physician' means a person authorized by law to practice medicine in this State and any other person authorized by law to treat sick and injured human beings in this State and to use narcotic drugs in connection with such treatment;" (Italics added.)

To fall within this definition of "physician", one must be "authorized by law to use narcotic drugs". Naturopaths are not so authorized.

Section 32-1466 allows sales of narcotics, among other things, to a physician, dentist or veterinarian. Section 32-1473 allows the professional use of narcotics by physicians, dentists or veterinarians. Nowhere does this Act allow the use of such drugs by Osteopaths, Naturopaths or others.

The Georgia case of *Association v. Allen* above referred to holds that physicians or practitioners of medicine as defined in the Uniform Narcotic Act refer only to those physicians who are qualified to practice all branches of medicine, not to the limited physicians such as Naturopaths and Osteopaths. It is true that our case of *Williams v. Capital Life and Health Insurance Company* holds that for certain purposes an Osteopath, a Homcopath, a Chiropractor, a Magnetic Healer and a Naturopath are practitioners in a field of medicine and a physician within their respective limited fields. However, that case involves only the right of a naturopath to sign certificates in connection with health and accident insurance. It does not touch upon the use of narcotics by such limited practitioners.

The case of *State Board of Medical Registration & Examination v. Scherer*, Indiana 1942, 46 NE 2d 602, 221 Ind. 92, is another case showing that Naturopaths generally are forbidden to prescribe or handle this type of drug.

Another statute of this State, now Section 56-1313,

prohibits the giving away, selling, distributing, or possession, except on a prescription of a duly licensed physician, dentist, or veterinarian, of a long line of drugs. There is nothing in this section allowing the handling of prescription of these drugs by Naturopaths. These include the sulfa drugs, abortifacient drugs, benzedrine, hormones and other derivative drugs.

Section 32-1496 forbids the sale of barbiturates or their compounds except upon a written prescription of a licensed physician or the prescription of a person authorized to prescribe narcotic drugs. Section 32-1497 provides that nothing contained in this chapter shall prevent the selling and handling of barbiturates by licensed physicians, licensed dentists, or licensed veterinarians. There is no exception here in favor of Osteopaths, Naturopaths and others of limited power.

In view of all of the above, and in view of the known dangers of the improper use of narcotics, barbiturates and the other restricted drugs, it is clear that the Legislature did not mean to allow Naturopaths to use or prescribe narcotics, barbiturates and the other restricted drugs. As will be seen in the article in American Jurisprudence on Physicians and Surgeons, each special type of healer or school of medicine is to be confined to its own theories and method of practice.

Historically, the practice of Naturopathy was a drugless practice, and still is. The exceptions made in the case of Osteopaths and Naturopaths, prohibiting them from the use of materia medica and surgery, can only mean that they were not to use these drugs and that they were not such physicians as are defined by the Uniform Narcotic Act.

There are several cases which say that merely because a certain course of study is prescribed in order to obtain a particular kind of license, that does not mean that the licensee is authorized to practice everything he studies. The following is taken from *Georgia Association of Osteopathic Physicians and Surgeons v. Allen*, 31 F Sup 213:

"It is true that applicants are examined in anatomy, physiology, chemistry, toxicology, pathology, diagnosis, hygiene, obstetrics, gynecology, surgery, medical jurisprudence, principles of osteopathy and such other subjects as the Board may require. However, the license authorized by 84-1209 does not necessarily include everything embraced in the examination. The license authorizes only the practice of osteopathy, which the same act classifies as a drugless school of practice. It may be necessary for an osteopath to know numerous subjects in order to make a diagnosis and to determine whether osteopathic treatment or some other treatment is indicated. He should know when not to give an osteopathic treatment.

"A chiropractor is examined in anatomy, physiology, symptomatology, pathology, physical diagnosis, neurology, chemistry, hygiene and sanitation, chiropractic orthopedy, nerve tracing and adjusting, as taught in chiropractic schools. His license, however, authorizes only the adjustment of patients (84-509). His knowledge must be broader than his practice; he must know what he practices but may not practice all he knows."

Upon the authorities above cited, it is my opinion that Naturopaths are not allowed to use narcotics, barbiturates and the other drugs contended for by them in the Complaint. It is, accordingly,

ORDERED that the Demurrer be, and it is hereby, sustained, and the Complaint is dismissed.

E. H. HENDERSON
PRESIDING JUDGE

October 11, 1954

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. A. T. Moore, Columbia, S. C.

Publicity Secretary: Mrs. N. D. Ellis, Florence, S. C.

DR. FRANK C. OWENS SPEAKS TO EXECUTIVE BOARD LUNCHEON THE SITUATION IN REGARD TO NATUROPATHS

Dr. Frank C. Owens spoke to the Executive Board of the Woman's Auxiliary to the South Carolina Medical Association at luncheon at the Forest Lakes Country Club in Columbia, Friday, November 12, on a phase of public relations, enlightening the group on the situation in regard to naturopaths. He began with a definition of naturopathic medicine which is rather ambiguous in itself and traced its origin back to 1896. Some of the existing Schools of Naturopathy are mere farces, Dr. Owens said, often not requiring a high school education, and awarding degrees after nominal lecture periods with no clinical work. He said the South Carolina Naturopathic Board was established in 1937 and requires a four-year high school course, two years of pre-medical work, and graduation from an accredited School of Naturopathy. South Carolina naturopathic physicians are privileged to use the state biology and chemical laboratories. There are three naturopathic hospitals in the State, according to Dr. Owens, at Travelers Rest, Seneca, and near Columbia. Naturopaths in this State are now seeking enactment of a state law which will enable them to write prescriptions and Dr. Owens pointed out the inherent dangers should that law be passed. He said the duty of medical doctors as he saw it was to protect the public from inferior, dangerous and pseudo-medical care, and as a remedy to the situation in regard to naturopaths he urged that their activities must be confined within the limits of their training and their licenses must be refused or revoked if they exceed these bounds.

Mrs. E. Gordon Able of Newberry, first vice-president of the state auxiliary, presided in the absence of the president, Mrs. Austin T. Moore of Columbia. The blessing was said by Mrs. H. L. Timmons.

Other guests present were Dr. and Mrs. O. B. Mayer (He is president-elect of the South Carolina Medical Association); Dr. Kirby D. Shealy (Dr. Shealy is president of the South Carolina Academy of General Practice and Mrs. Shealy is a councilor for the Woman's Auxiliary to the Southern Medical Association); Dr. and Mrs. A. F. Burnside (Dr. Burnside is a member of the board of trustees of the Medical College of South Carolina and Mrs. Burnside is a director of the Woman's Auxiliary to the A. M. A.); and Mrs. Leon Bryan, president of the Columbia League of Women Voters.

Beautiful autumn flowers decorated the tables and miniature figures of doctors and nurses standing on tiny pill boxes made attractive place cards. Mrs. R. F. Haines of Columbia was in charge of decorations.

A business meeting was held preceding the luncheon at which Mrs. C. R. May, Jr., of Bennettsville, president-elect, led in the auxiliary pledge. Mrs. A. T. Moore's president's report was read by Mrs. H. L. Timmons in the absence of the president due to illness. The Board voted to express their appreciation to Mrs. E. Gordon Able, first vice-president, for her capable presiding in Mrs. Moore's absence and instructed the secretary to write Mrs. Moore expressing how much her presence was missed and extending best wishes for her speedy recovery.

Reports were heard from state officers, state chairmen, and county presidents. These reports in-

corporated plans for the year. Mrs. Alton G. Brown, chairman of the Jane Todd Crawford Loan Fund and Nurse Recruitment announced that February 6-12 would be State Nurse Recruitment Week and the State Rally for Future Nurses Clubs would be held at Winthrop College February 11 and 12. Mrs. Brown stated that most Schools of Nursing in South Carolina have capacity student loads and that some of the credit is certainly due the Auxiliary for their constant work in the field of Nurse Recruitment. She also said that there have been fewer "drop-outs" this year, partly because high school girls are finding out through Future Nurses Clubs if they are suited for nursing careers.

Mrs. David F. Adcock of Columbia, chairman of the Student Loan Fund, reported that two medical students are being assisted by loans and read letters from each of these young men expressing their appreciation to the Auxiliary for the aid they are receiving. Both are students at the Medical College in Charleston.

From the reports of county presidents it was evident that each auxiliary in the state will endeavor to increase its membership this year. Many auxiliaries are giving financial aid to student nurses; many are helping to promote social activities for nurses in towns where hospitals are situated; many are cooperating with community health projects; all are working on nurse recruitment and various phases of public relations. Sumter Auxiliary has established a Memorial Fund for Mrs. Davis Moise and Charleston for Mrs. B. O. Ravenel. Program topics include Civil Defense, Mental Health, Safety, Excess Weight—(Cause and Cures), Cancer, Heart Disease, American Medical Association, Animal-Carried Diseases, Socialized Medicine in Australia and England, New Techniques in X-Ray, Juvenile and Domestic Courts, and many other pertinent subjects, as well as programs designed to promote sociability and better public relations.

Presidents-elect of county auxiliaries were invited to attend this board meeting. It was announced that the annual Convention would be held in Charleston, May 9-12. Mrs. Richie H. Belser of Charleston is chairman and Mrs. K. M. Lippert of Columbia is co-chairman. The president of the Woman's Auxiliary to the A. M. A., is to be our guest.

The following nominating committee was elected:

Mrs. David A. Wilson, Greenville
Mrs. Kirby D. Shealy, Columbia
Mrs. Alton G. Brown, Rock Hill

PARAPHRASE ON THE PHYSICIANS HIPPOCRATIC OATH FOR DOCTORS' WIVES

I swear by Minerva, the goddess of wisdom, by Venus, Juno, Vesta and the Penates, goddesses of love, womanhood and the home, that according to my ability and judgment I will keep this oath and stipulation: to reckon this profession, which I share, sacred; to share its hardship equally with my husband as well as its benefits; to share his disappointments with good grace and with such tolerance that they shall be easier for him to bear; to teach our children the importance of respecting the medical profession and of regarding as confidential any knowledge which may come to them by accident in our home.

I will follow the system of regimen which, according to my best judgment, I consider best for the doctors' household and will abstain from whatever is

unsuitable for a physician's home. I will give out no information, if asked, which I have not the authority to give. With purity and holiness will I pass my life and practice my art of home-making.

Whatever in connection with my husband's professional practice or not in connection with it, I may see or hear, I will not divulge, holding that all such things should be kept secret. I will abstain from any display which might be deemed unfitting to a doctor's wife and will be sure at all times that jealousy does not enter into my life or that of my husband. I will refrain from disparaging comment about any of my husband's colleagues, remembering always that not all personalities and viewpoints can be alike.

While I continue to keep this oath inviolate, may it be granted to me to enjoy life and to help my husband to practice his profession, respected always by all who know us both; but should I break through and violate this oath, may the reverse be my lot.

Elizabeth D. Whetsell
Public Relations Committee

SOUTH CAROLINA ACADEMY OF GENERAL PRACTICE

Fellow General Practitioners: Approximately 130 doctors took advantage of the Post Graduate Seminar and Founders' Day program November 2, 3 and 4 this year. There were separate registrations for the two day seminar (95) and Founders' Day (84). The program was excellent and was carried through as scheduled. Many favorable comments were made by those attending. Our only regrets were that so many of our doctors were unable to attend. We should have had at least 400 present. Where were you?

The two day Seminar was put on by members of our Medical College Faculty: professors, associates, and assistants. It does one good to sit in the audience and listen to these lecturers, every one well qualified and well prepared in his particular field of medicine. We always learn a great deal by this experience and we also realize with a great deal of pride that our Medical College is right up front with the best in the country. President Lynch and Dean Cuttino deserve our praise and congratulations for keeping our school "abreast with the best".

The Founders' Day program was composed of invited guest speakers. These speakers too were well prepared and brought something of interest and practical value to the general practitioner as well as to the specialist.

Highlighting the Founders' Day program were two items of special order: one—the presentation of a portrait of Dr. William Weston of Columbia to the Medical College, the other—the presentation of a plaque of Dr. Daniel Lesesne Smith of Spartanburg to the Medical College. It was an inspiration to hear the beautiful and well deserved tributes paid these two great South Carolina pediatricians.

The Medical College luncheon was another highlight of the day. It was well attended. Here there was good food, good fellowship and greeting of old friends.

Our Medical College physical plant is expanding rapidly and keeping up with the progress of medicine. The Alumni Memorial House is ready for occupancy and was open for inspection and dedicated at this

DOCTORS' WIFE

The doctors' wife is brave indeed . . . Because she has to live . . . With him who loves her but who has . . . So little time to give . . . He wants to linger at her side . . . From morning until night . . . But always there are patients in . . . Their sad and painful plight . . . And always there are calls that come . . . At dinner or at dawn . . . And true to his profession, he . . . Gets up and he is gone . . . He may amass a fortune for . . . His loving wife to spend . . . And now and then she may enjoy . . . The comforts of a friend . . . But all in all they have to make . . . A heavy sacrifice . . . And Mrs. Doctor has to pay . . . Her portion of the price.

James J. Metcalfe

Helen Hayes, in speaking for Careers in Nursing said, "If you learn to take care of others, you can always take care of yourself."

meeting. The new College Hospital is nearing completion and it is planned to have it open for inspection in May 1955 when the annual South Carolina Medical Association meeting is in session.

Fellow practitioners of medicine, it is a wonderful experience to go back to Charleston for a meeting and attending these seminars should be a "must" for all of us. You come away feeling refreshed by a few days rest from your routine work, encouraged by having absorbed some up-to-date medical knowledge and mighty proud that you are an alumnus of our grand old school.

Kirby D. Shealy, M. D., President

COLLEGE OF PHYSICIANS

At the Southeastern Regional Meeting of the American College of Physicians held October 15-16 at Gulfport, Mississippi, Dr. Robert Wilson, who is Governor of the College for South Carolina, presided as Toastmaster for the banquet.

A paper on the Prophylactic Use of Quinidine Following Myocardial Infarction by Dr. John A. Boone and Dr. Anthony Pappas was presented by Dr. Pappas.

Dr. Boone participated in a discussion on Mitral Commissurotomy.

Dr. Dale Groom, recently appointed Asst. Professor of Medicine, presented a paper on "The Sea Gull Murmur and Murmurs Heard at a Distance From the Chest Wall". This paper, written in collaboration with Dr. Boone, sets forth some of the research studies being carried out in the Heart Sound Laboratory at the Medical College.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Office of the Secretary
Robert L. Faulkner, M. D.
2105 Adelbert Road
Cleveland 6, Ohio

The next scheduled examination (Part 1), written examination and review of case histories, for all candidates will be held in various cities of the United States, Canada, and military centers outside the continental United States, on Friday, February 4, 1955.

Case Abstracts numbering 20 are to be sent by the candidate to the Secretary as soon as possible after receiving notification of eligibility to the Part I written examination.

INDEX FOR VOLUME 50

AUTHOR INDEX

	Page
A	
Adams, Anne S. -----	164
Arena, Jay M. -----	8
B	
Bailey, Frank H. -----	362
Baker, C. R. F. -----	255
Banov, Leon -----	370
Blumberg, Richard W. -----	198
Bridgers, William H -----	321
Buie, Louis A. -----	260
Byrnes, James F. -----	187
C	
Coleman, Ralph R. -----	31
D	
Daniel, Rollin A., Jr. -----	195
F	
Freeman, Barney L., Jr. -----	325
G	
Gregg, David B. -----	353
H	
Hagerty, Robert F. -----	12
Hoch, J. Hampton -----	137
Holman, Cranston W. -----	268
Holt, Rebie -----	76
Hoople, Gordon D. -----	132
Howell, Roy A., Jr. -----	76
J	
Jeffords, Joseph V. -----	129
K	
Keyes, Baldwin L. -----	289
Kunkle, E. Charles -----	161
L	
Latham, Elizabeth B. -----	357
Lehman, Edwin P. -----	1
Lide, L. D., Jr. -----	71
M	
McCain, John R. -----	45
McKee, K. T. -----	40
Martin, Luther C. -----	129
Mayo, Henry W., Jr. -----	99, 264
Moseley, Vince -----	95
O	
Owens, Frank C. -----	372
P	
Paul, John R., Jr. -----	65
Pettit, Harold -----	200
Pollitzer, Richard M. -----	104
Pratt-Thomas, H. R. -----	332
R	
Riley, Kathleen A. -----	39, 164, 300
Ross, Robert A. -----	157
S	
Smith, David T. -----	190
Story, Stacy H. -----	76

	Page
Suhrer, Julian G. -----	1
W	
Walsh, Theo. E. -----	296
Wilkinson, George -----	374
Woodhall, Barnes -----	8

SUBJECT INDEX

A	
Accidents, Childhood, (Barnes Woodhall and Jay M. Arena) -----	8
Address, (James F. Byrnes) -----	187
A.M.A. in San Francisco, Report of a Delegate to, (Ed.) -----	239
American Medical Education Foundation, (Ed.) -----	82
Anesthesiologist, Rambling With An, Through Judicial Decisions of South Carolina (Frank H. Bailey) -----	362
Aneurysm, Dissecting, of the Aorta (Pathological Conference) -----	165
Aneurysm of the Brain, Arteriovenous, (Luther C. Martin and Joseph V. Jeffords) -----	129
Announcements -----	250, 282, 313, 340
Annual Meeting, (Ed.) -----	114, 170
Anti-antibiotics, (Ed.) -----	18
Antibiotics and Sulfonamide Therapy, The Incidence of, (Kathleen Riley) -----	39
Appendectomy, Rationale of, (Edwin P. Lehman and Julian G. Suhrer) -----	1
Arteriovenous Aneurysm of the Brain, (Luther C. Martin and Joseph V. Jeffords) -----	129
Aorta, Dissecting Aneurysm of (Pathological Conference) -----	165
Ataxia, Friedreich's (Pathological Conference) -----	302
B	
Babel in Brief, (Ed.) -----	18
Blue Cross—Blue Shield -----	244, 277, 380
Editorials: -----	54, 82, 241, 276
Botany, Medical, in South Carolina Two Centuries Ago, (J. Hampton Hoch) -----	137
C	
Cancer, Lung, The Differential Diagnosis of, (Rollin A. Daniel, Jr.) -----	195
Carcinoma of the Ampulla of Vater, Pancreaticoduodenectomy for, (Henry W. Mayo, Jr.) -----	99
Chemotherapy in Tuberculosis, (David B. Gregg) -----	353
Chest, Non-Tuberculous Diseases of the; Pediatric Aspects, (Richard W. Blumberg) -----	198
Childhood Accidents, (Barnes Woodhall and Jay M. Arena) -----	8
Charity at Home, (Ed.) -----	273
Choice of Physician in England, (Ed.) -----	306
Cleft Lip, (Robert F. Hagerty) -----	12
Correspondence -----	19, 55, 85, 278, 348
Cortisone, (Ed.) -----	306
Courtesy and Custom, (Ed.) -----	115
Cytology, Exfoliative, The Value of, (H. R. Pratt-Thomas) -----	332

	Page		Page
D		M	
Diets for Patients with Heart Disease	126	Maternal Deaths, Improved Diets as a Means of Reducing	211
Diets, Improved, as a Means of Reducing Maternal Deaths	211	Maternal Mortality in a Rural State, Factors Influencing, (Robert A. Ross)	157
Dizziness, Vertigo and, (Vince Moseley)	95	Mayer, O. B., Jr.	172
Doctor Examines His Profession, (C. R. F. Baker)	255	Mayer, Orlando Benedict, III	171
E		Medical College Expansion with Regard to The Roper Hospital and the Community, Suggestions Regarding, (Ed.)	376
Editor, A New, and a New Board, (Ed.)	19	Medical College Hospital, Challenge and an Opportunity Face Charleston Community Medicine upon the Opening of the, (Ed.)	204
Exfoliative Cytology, The Value of, (H. R. Pratt-Thomas)	332	Meniere's Disease, The Diagnosis and Treatment of, (Theo. E. Walsh)	296
F		Mortality Statistics, How Dependable are? (Ed.)	239
Family Doctor in Psychotherapy, The Importance of the, (Ralph R. Coleman)	31	N	
Fees, Professional, and Public Relations, (Ed.) ..	53	Naturopaths Bring Suit, (Ed.)	273
Forty Years Ago	19, 55, 82, 116, 141, 171, 242, 278 308, 338, 379	[Naturopathy], Opinion of Judge Henderson on Naturopath's Suit	386
Founders Day, (Ed.)	307	Naturopathy, South Carolina's Statutes Concerning	382
Friedreich's Ataxia (Pathological Conference) ..	302	Neoplasms, Pulmonary, X-Ray Diagnosis of, (Harold Pettit)	200
G		Neuroses in General Practice, Treatment of, (Baldwin L. Keyes)	289
Gamma Globulin, (Ed.)	306	News Items	20, 56, 84, 123, 147, 180, 248, 280, 308, 345, 382
Gamma Globulin Gloom, (Ed.)	114	O	
Gamma Globulin in Poliomyelitis Prevention and Modification—1954, (Ed.)	203	Omnia in Risu	84, 141, 242
Georgia Medical Society Sesquicentennial, (Ed.) ..	376	Orthopaedic Appliances, Physiological Principles of Some, (Barney L. Freeman, Jr.)	325
Glaucoma and the general practitioner, (L. D. Lide, Jr.)	71	P	
Gonococcal Urethritis with Bacteremia, (Roy A. Howell, Jr., Stacy H. Story and Rebie Holt) ..	76	Pancreatico-Duodenectomy for Carcinoma of the Ampulla of Vater, (Henry W. Mayo, Jr.)	99
H		Pathological Conference, Medical College of South Carolina	77, 165, 302
Hazards to our Kind of Medicine, (Ed.)	114	Pediatrics—Then and Now, (Richard M. Pollitzer)	104
Head Injuries, Emergency Treatment of, (William H. Bridgers)	321	Peoples, Dr. G. S. T., New State Health Officer, (Ed.)	245
Health Insurance, Doctors Help Increase the Cost of, (Ed.)	82	Peptic Ulcer, Surgical Management of, (Cranston W. Holman)	268
Hearing Handicapped, Help for the, (Gordon D. Hoople)	132	Peptic Ulcer From the Surgical Viewpoint, The Clinical Significance of, (Henry W. Mayo, Jr.) ..	264
Heart, Congenital Malformation (Anomalous Right Subclavian Artery) (Pathological Conference)	77	Polio, Promise for, (Ed.)	18
Heart Disease, Diets for Patients with	126	Polio Vaccine Trial Needs Physicians' Aid as it Moves into Evaluation Phase, (Ed.)	241
Hemorrhage in the Last Half of Pregnancy, The Management of, (John R. McCain)	45	[Poliomyelitis], Physician's contribution, (Ed.) ..	211
I		Postmaturity, (Ed.)	114
Injuries, Head, Emergency Treatment of, (William H. Bridgers)	321	Pregnancy, The Management of Hemorrhage in the Last Half of, (John R. McCain)	45
J		Premature Mortality of Roper Hospital, (Elizabeth B. Latham)	357
Judgment for Solomon, (Ed.)	275	President's Page	206, 247, 281, 312, 350, 384
Judicial Decisions of South Carolina, Rambling With An Anesthesiologist Through, (Frank H. Bailey)	362	Pressly, William Lowry, (Ed.)	337
L		Priece, Dr. Julian, Commended, (Ed.)	170
Laboratory Fee, (Ed.)	140	Proetologic Problems, Common, (Louis A. Buie) ..	260
Latin—Dead and Buried Dog, (Ed.)	337	Psychotherapy, The Importance of the Family Doctor in, (Ralph R. Coleman)	31
Learn While You Ride, (Ed.)	52		
Lip, Cleft, (Robert F. Hagerty)	12		
Literary Progress, Medical, (Ed.)	114		
Lung Cancer, The Differential Diagnosis of, (Rollin A. Daniel, Jr.)	195		

	Page		Page
Public Relations, Two Sides of, (Ed.)	52	American College of Surgeons	26
Pulmonary Neoplasms, X-Ray Diagnosis of, (Harold Pettit)	200	Bill for Aid to Health Plans	25
Pulmonary Tuberculosis, The Changing Epidemiological and Clinical Pattern of, (David T. Smith)	190	Doctor and the Press	92
R		Future of Private Practice	89
Rickets, Resistant, (John R. Paul, Jr.)	65	General Practice and Medical Research	25
Roper Hospital, Premature Mortality of, (Elizabeth B. Latham)	357	Health and Accident Insurance Studied	23
Rose in the Hand, (Ed.)	114	Ideal Doctor	64
S		Homeopathic Board Proposed	90
Smith, Lesesne, Presentation Speech at Unveiling of a Plaque Commemorating Dr. Lesesne Smith, (George Wilkinson)	374	"Humanities"	62
Smith, William Atmar, Address Made at the Presentation of a Plaque of, (Leon Banov)	370	Invitation to Frank Discussion	154
South Carolina Academy of General Practice	348, 390	Legacy of a Great Physician	156
South Carolina, Medical Botany in, Two Centuries Ago, (J. Hampton Hoch)	137	Manners of the Profession	156
South Caroliniana (Abstracts)	213, 284	Medical Public Relations	150
Southern Medical Association, (Ed.)	306	President's Health Message	60
Southern Pediatric Seminar, (Ed.)	170	Professional Liability Insurance Called "Serious Problem Nationally"	184
State Board of Health	143, 308, 337	Wolverton and Smith Bills for Re-insurance	217
Sulfonamide Therapy, The Incidence of Antibiotics and, (Kathleen Riley)	39		
T		SOUTH CAROLINA MEDICAL ASSOCIATION	
Tennessee Plan, (Ed.)	170	Annual Meeting	108
Tinea Capitis, (Anne S. Adams and Kathleen A. Riley)	164	Annual Session (106th)	219
Tinea Capitis, (Kathleen A. Riley)	300	Committee Reports	175
Tuberculosis, Chemotherapy in, (David B. Gregg)	353	Committees, 1954-55	272
Tuberculosis, Pulmonary, The Changing Epidemiological and Clinical Pattern of, (David T. Smith)	190	Committee Reports to the House of Delegates	118
U		Council Meeting Minutes, Myrtle Beach, S. C., May 10, 1954	172
Urethritis, Gonococcal, with Bacteremia, (Roy A. Howell, Jr., Stacy H. Story and Rebek Holt)	76	Council Meeting Minutes, Myrtle Beach, S. C., May 11, 1954	174
V		Council Meeting Minutes, Myrtle Beach, S. C., May 12, 1954	174
Varicose Veins, (Ed.)	140	Council Meeting Minutes, Myrtle Beach, S. C., May 13, 1954	175
Vertigo, Central Causes of, (E. Charles Kunkle)	161	Council Meeting Minutes, Columbia, S. C., Sept. 29, 1954	338
Vertigo and Dizziness, (Vince Mosley)	95		
Virus Infections, Notes on the Treatment of, (K. T. McKee)	40	BOOK REVIEWS	
Voluntary Health Insurance, Physician and, (Ed.)	81	Anatomy and Surgery of Hernia, Zimmermann and Anson	22
W		Atlas of Pelvic Operations, Langdon and Ulfelder	145
Weston, William, Presentation of Dr. William Weston's Portrait to the Medical College of South Carolina, (Frank C. Owens)	372	Beyond the Germ Theory, Galston	310
Wiggly Hingley, (Ed.)	139	Children for the Childless, Fishbein	172
Woman's Auxiliary	59, 87, 126, 149, 182, 252, 288, 315, 389	Clinical Management of Behavior Disorders in Children, Bakwin and Bakwin	22
Wyman, Dr. Ben F., An Appreciation by the Executive Committee of the State Board of Health, (Ed.)	246	Current Therapy 1954, Conn	145
		Disability Evaluation, McBride	145
		Diseases of Women, Crossen	86
		Emergency Treatment and Management, Flint	286
		Fundamentals of Anesthesia, American Medical Association	341
		Hepatic Circulation and Portal Hypertension, Child	212
		History of Psychoanalysis in America, Oberndorf	145
		Illustrative Review of Fracture Treatment, Liebolt	310
		Living with a Disability, Rusk and Taylor	145
		Manual of Clinical Mycology, Conant et al.	213
		Manual of Tropical Medicine, Mackie et al.	212
		Mayo Clinic Diet Manual, Committee on Dietetics of the Mayo Clinic	212
		Modern Clinical Psychiatry, Noyes	122

Ten Point Program

A.M.A. House of Delegates in Interim Session 24

	Page		Page
My Health Record, <i>Cantey</i>	144	Daniel, H. M.	85
Pelvic Relaxations and Herniations, <i>Wilson</i>	86	Deas, Henry	123
Peripheral Circulation in Man, (<i>Ciba</i>)	341	Edenfield, J. R.	21
Peripheral Nerve Injuries, <i>Haymaker and Wood-</i> <i>hall</i>	22	Fender, Marion	249
Physical Examination of the Surgical Patient, <i>Dumphy and Botsford</i>	22	Gaston, John Newton	346
The Physician and his Practice, <i>Garland</i>	341	Kennedy, David Ross	146
Planning Florida's Health Leadership, <i>Poor</i>	310	Kibler, Clarence LeRoy	250
Regional Block, <i>Moore</i>	85	Lyles, William Boykin	309
Review of Physiological Chemistry, <i>Harper</i>	86	McCutchen, R. O.	59
Salt and the Heart, <i>Yorke</i>	87	McElroy, A. P.	309
Source Book of Medical Terms, <i>Jaeger</i>	86	Mason, Robert Elijah	380
Surgical Forum, <i>American College of Surgeons</i> ..	341	Moore, James Henry	147
Textbook of Pediatrics, <i>Nelson</i>	341	Perry, William Joel	309
Thoracic Surgery, <i>Sweet</i>	145	Pressly, William Lowry	337
D E A T H S			
Allan, Sarah C.	122	Rogers, W. C.	123, 146
Bishop, Benjamin Clyde	380	Salters, A. De L. B.	213
Blake, Clough Henry	380	Sparkman, E. H.	123
Boggs, Luther W.	146	Stuart, Garden Clarkson	309
Christopher, Richard G.	146	Stuckey, T. M.	122
Clayton, Hubert	380	Stukes, J. P., Sr.	284
Cousar, John B.	380	Teal, D. T.	284
Culbreath, P. H., Jr.	146	Tuten, John King Garnett	348
		Woodruff, William A.	146
		Wyman, Benjamin F.	249
		Zerbst, George Henry	21





